

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14379

14388

1. DECEASED NAME (Type or print) <b>Nina Minnie Ambush</b>			2a. DATE OF DEATH Month <b>October</b> Day <b>3</b> Year <b>1968</b>			2b. HOUR <b>12:00</b>					
3. SEX <b>Female</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH <b>2-10-1902</b>		6. AGE (In years last birthday) <b>66</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>Md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Frederick</b> Md.					
10. CITY OR TOWN OF DEATH <b>Frederick</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Frederick Memorial</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY *****		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>			13b. COUNTY <b>Frederick</b>			13c. CITY OR TOWN <b>Frederick</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>116 E. 5th St, Fred. Md</b>	
14. FATHER'S NAME First <b>John</b> Middle <b>Clarence</b> Last <b>Norris</b>			15. MOTHER'S MAIDEN NAME First <b>Minnie</b> Middle <b>NMN</b> Last <b>Plater</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service) <b>*****</b>					
16b. SOCIAL SECURITY NO. <b>UNKN</b>			17. INFORMANT Address <b>Frederick, Md</b> <b>Robert S. Ambush 116 E. 5th St</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Left Lung</b> <b>1621</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>163X</b>											
19a. DATE OF OPERATION <b>10-5-1968</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 22</b> , 19 <b>59</b> , to <b>Oct 3</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>Oct 6</b> , 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Thomas Stone</b>				DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10-3-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Thomas Stone</b>				22e. ADDRESS <b>Frederick MD</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-5-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fairview</b>		23d. LOCATION (City or Town) (County) (State) <b>Frederick Fred. Md</b>					
24. FUNERAL DIRECTOR <b>C.E. Hicks, 111 Frederick, Md</b>				25a. REC'D BY REGISTRAR DATE <b>OCT 7 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-21b Film 407  
11-29-68 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14527

1. DECEASED NAME (Type or Print) <b>William Alfred Ambush</b>			First Middle Last			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year 10-30 1968			2b. HOUR PM 3:30						
3. SEX <b>Male</b>		4. RACE <b>C</b>		5. DATE OF BIRTH <b>4-29-1925</b>		6. AGE (in years last birthday) <b>43</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN					
7a. BIRTHPLACE (State or foreign country) <b>Ma</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Frederick</b> Md						
10. CITY OR TOWN OF DEATH <b>Frederick</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>D.O.A. Fred Memorial</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Cook</b>				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Ma</b>				13b. COUNTY <b>Frederick Adamstown</b>				13c. CITY OR TOWN <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER <b>Rt 1</b>			
14. FATHER'S NAME <b>Roy Linwood Ambush</b>						15. MOTHER'S MAIDEN NAME <b>Virginia Evana Price</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>WW11</b>		17. INFORMANT <b>Virginia E. Ambush</b>						ADDRESS <b>Rt 1 Adamstown, Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Acute alcoholism and intravenous barbiturate - Anesthesia</b> 9361												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 954X															
19a. DATE OF OPERATION <b>10/30/68</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>Abscess tooth</b>						20. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year No injury				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.				City or Town		County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <b>Robert J. Thomas</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Robert J. Thomas</b>				ADDRESS (Street, city, town, or county) <b>Frederick, Md</b>				DATE SIGNED <b>Oct 30, 1968</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE <b>11-2-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's</b>				23d. LOCATION (City or Town) (County) (State) <b>Della Fred. Md</b>					
24. FUNERAL DIRECTOR <b>C.E. Hicks, 111 Frederick, Maryland</b>						25a. REC'D BY REGISTRAR <b>NOV 4 1968</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

720

ZAL-2001-0-1

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11

21 [2010.12.12] 2010.12.12

Small, *et al.* 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 267

14381

## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>ELIZABETH A. BAYNE</b>			2a. DATE OF DEATH Month <b>OCTOBER</b> Day <b>25</b> Year <b>68</b>			2b. HOUR <b>M</b>						
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>SEPT. 11, 1881</b>		6. AGE (In years last birthday) <b>87</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>		
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>FREDERICK</b>						
10. CITY OR TOWN OF DEATH <b>FREDERICK</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>FREDERICK MEMO. HOSP</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>COOK</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>FOOD</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>			13b. COUNTY <b>1</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>4348 SHELDON AVE</b>			
14. FATHER'S NAME First <b>JACOB</b> Middle <b>DURM.</b> Last <b>?</b>			15. MOTHER'S MAIDEN NAME First <b>?</b> Middle <b>?</b> Last <b>BOPP</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>21524-9533A</b>		17. INFORMANT Address <b>JOSEPH C. BAYNE 4348 SHELDON</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>4201</b> (b) <b>coronary artery disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>pneumonia</b>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>? CVA</b>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>10/68</b> , 19__, to <b>10/25/68</b> , 19__, that (I) (we) last saw the deceased alive on <b>10/25/68</b> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>A. Austin Pearne, Jr.</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10/26/68</b>				
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>10/28/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>HOLT REDEEMED</b>			23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE</b>			
24. FUNERAL DIRECTOR <b>VULTRICH FUNERAL HOME - 4210 BELMONT</b>						25a. REC'D BY REGISTRAR DATE <b>OCT 29 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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Items 18, 20 & 22a Film 406 MARYLAND STATE DEPARTMENT OF HEALTH  
11-20-68ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14382

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15230

1. DECEASED-NAME (Type or Print) <b>Beatrice Louise Beard</b>				2a. DATE KNOWN OF DEATH Month <b>Oct.</b> Day <b>15</b> Year <b>68</b>				2b. HOUR <b>PM</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>10-9-1927</b>	6. AGE (in years last birthday) <b>41</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>	2c. DATE PRONOUNCED DEAD Month <b>Oct</b> Day <b>15</b> Year <b>1968</b>			2d. HOUR <b>PM</b>
7a. BIRTHPLACE (State or foreign country) <b>Fred. Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Frederick</b> Md			
10. CITY OR TOWN OF DEATH <b>Frederick</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Frederick Memorial Hos</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Clerk</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Stock Sale</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Fred.</b>		13c. CITY OR TOWN <b>Thurmont</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>RD 2 Creagerstown</b>	
14. FATHER'S NAME First <b>John B.</b> Middle <b>Wisner</b> Last <b></b>				15. MOTHER'S MAIDEN NAME First <b>Mary R.</b> Middle <b>Fogle</b> Last <b></b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16b. SOCIAL SECURITY NO. <b>213-24-9122</b>		17. INFORMANT ADDRESS <b>Austin S. Beard Thurmont Md. RD 2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>3459</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Congestive heart failure</b> (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Idiopathic epilepsy</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>3533</b>									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M. <b></b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. <b></b>		City or Town <b></b>		County <b></b> State <b></b>	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Robert R.R. Roberts</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Robert R.R. Roberts</b>				ADDRESS (Street, city, town, or county) <b></b>		22b. DATE SIGNED <b>Oct. 15, 1968</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-18-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Thurmont Fred. Co. Md.</b>			
24. FUNERAL DIRECTOR <b>Raymond E. Creager</b>				ADDRESS <b>Thurmont, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 18 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	





**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 4.5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14383		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										14390					
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or Print)						First Middle Last			2a. DATE KNOWN OF DEATH				2b. HOUR				
<b>James Edgar BOWENS</b>									Month Day Year <b>10 23 1968</b>				? M.				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD		2d. HOUR			
<b>Male</b>		<b>Negro</b>		<b>11-11-1895</b>		<b>72 YRS</b>						Month Day Year <b>10 23 1968</b>		<b>4:30 PM</b>			
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH					
<b>MD</b>				<b>U.S.A.</b>								<b>Fredrick</b>					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY					
<b>Buckeystown</b>				<b>Buckeystown Box 62</b>				<b>Brickworks</b>				<b>****</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
<b>MD</b>				<b>Fredrick Buckeystown</b>										<b>Box 62</b>			
14. FATHER'S NAME						First Middle Last			15. MOTHER'S MAIDEN NAME						First Middle Last		
<b>Will NMN BOWENS</b>									<b>Cal NMN BROOKS</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS									
<b>No</b>						<b>*****</b>		<b>Fredrick, MD</b> <b>219-20-3747 Lola Bowens Hall 109 S. Bentz St</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4129</b> (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF <b>4221</b> (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>GI Bleeding &amp; Hematuria</b>																	
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.				City or Town		County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <b>Robert J. Thomas</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						22b. DATE SIGNED <b>10/24/68</b>					
EXAMINER'S NAME (Type) <b>Robert J. Thomas, M.D.</b>						ADDRESS (Street, city, town, or county)											
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE <b>10-26-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hopewell</b>				23d. LOCATION (City or Town) <b>Hopewell Fred.</b>		(County) <b>MD</b>		(State)			
24. FUNERAL DIRECTOR <b>C.E. Hicks, 111 Frederick, MD</b>						25a. REC'D BY REGISTRAR DATE <b>OCT 28 1968</b>				25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

14384

14391

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Fred.</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN 1b <u>yr</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Frederick Nursing Home</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Adamstown</u>			
				d. STREET ADDRESS <u>—</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>LOUISE</u> Middle <u>Davis</u> Last <u>BROSIOUS</u>				4. DATE OF DEATH Month <u>OCT.</u> Day <u>20</u> Year <u>1968</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/10/1886</u>	
9. AGE (in years last birthday) <u>82</u> yrs.		10. FINDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Frederick Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even, if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
13. FATHER'S NAME <u>Wallace Davis</u>				14. MOTHER'S MAIDEN NAME <u>Harriet Hays</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-10-9757</u>			
17. INFORMANT <u>J. Wm. Brosious</u>				Address <u>8906 Fernwood Rd Bethesda, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic heart dis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Diabetes Mellitus</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1954</u> <u>1948</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4200</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1948</u> , 19 <u>—</u> , to <u>Oct</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Sept 3</u> , 19 <u>68</u> , and that death occurred at <u>2 A</u> .M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles H Conley, Jr</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>21 Oct. 1968</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/22/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Monacacy</u>		23d. LOCATION (City, town or county) (State) <u>Beallsville Md.</u>	
24. FUNERAL DIRECTOR <u>Constance C Hilton Barnesville Md</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>			
				25b. REGISTRAR'S SIGNATURE <u>—</u>			



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

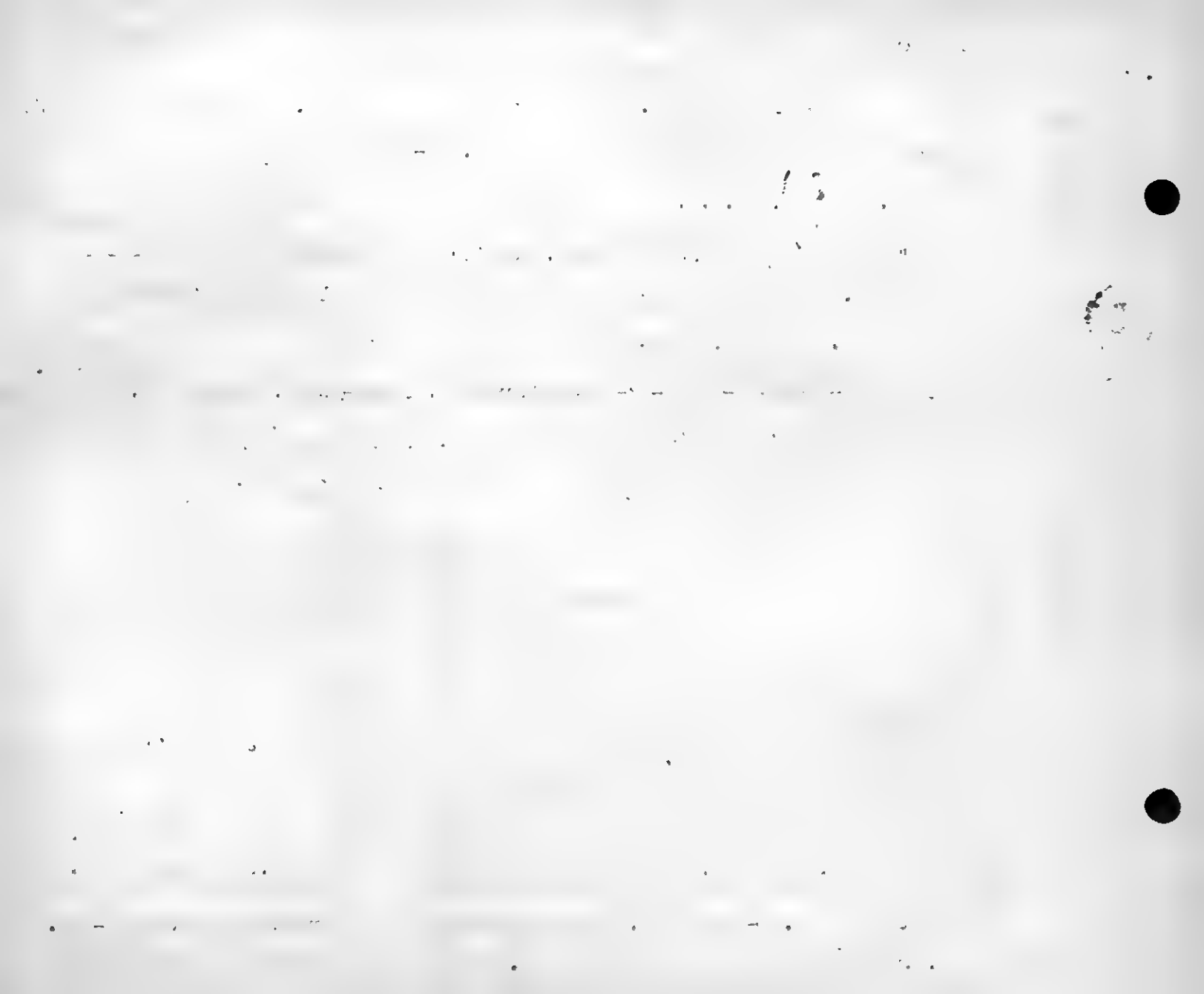
14385

CERTIFICATE OF DEATH

14392

1. DECEASED-NAME (Type or print) <b>Pauline A. Brown</b>			2a. DATE OF DEATH Oct. Month 10 Day 68 Year			2b. HOUR P 4:25 M				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Jan. 25- 1889</b>		6. AGE (In years last birthday) <b>79</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Frederick</b> Md.				
10. CITY OR TOWN OF DEATH <b>Frederick</b>			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Frederick Mem. Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Homemaker</b>			12b. KIND OF BUSINESS OR INDUSTRY -----	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Frederick</b>		13c. CITY OR TOWN <b>Frederick</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>100 Monroe Avenue</b>	
14. FATHER'S NAME First Middle Last <b>Wm. A. Roberts</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Emma Smith</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <b>213-12-7860</b>		17. INFORMANT Address <b>Frederick-Md.</b> <b>Raymond S. Brown-366 W. Patrick St.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral, arteriosclerotic heart failure</b> <b>4517</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Multiple cerebral vessel disease, cerebral</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2m</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept</b> , 19 <b>68</b> , to <b>10/14</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10/14</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Robert S. Hughes</b>			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>10 Oct 68</b>				
22d. PHYSICIAN'S NAME (Type) <b>Dr. Robert S. Hughes</b>			22e. ADDRESS <b>700 Montclair Ave., Frederick, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>Oct. 14-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Frederick Frederick-Md.</b>		
24. FUNERAL DIRECTOR <b>Elwood T. M.R. Etchison &amp; Son</b>			ADDRESS <b>Frederick, Md. 21701</b>			25a. REC'D BY REGISTRAR DATE <b>OCT 14 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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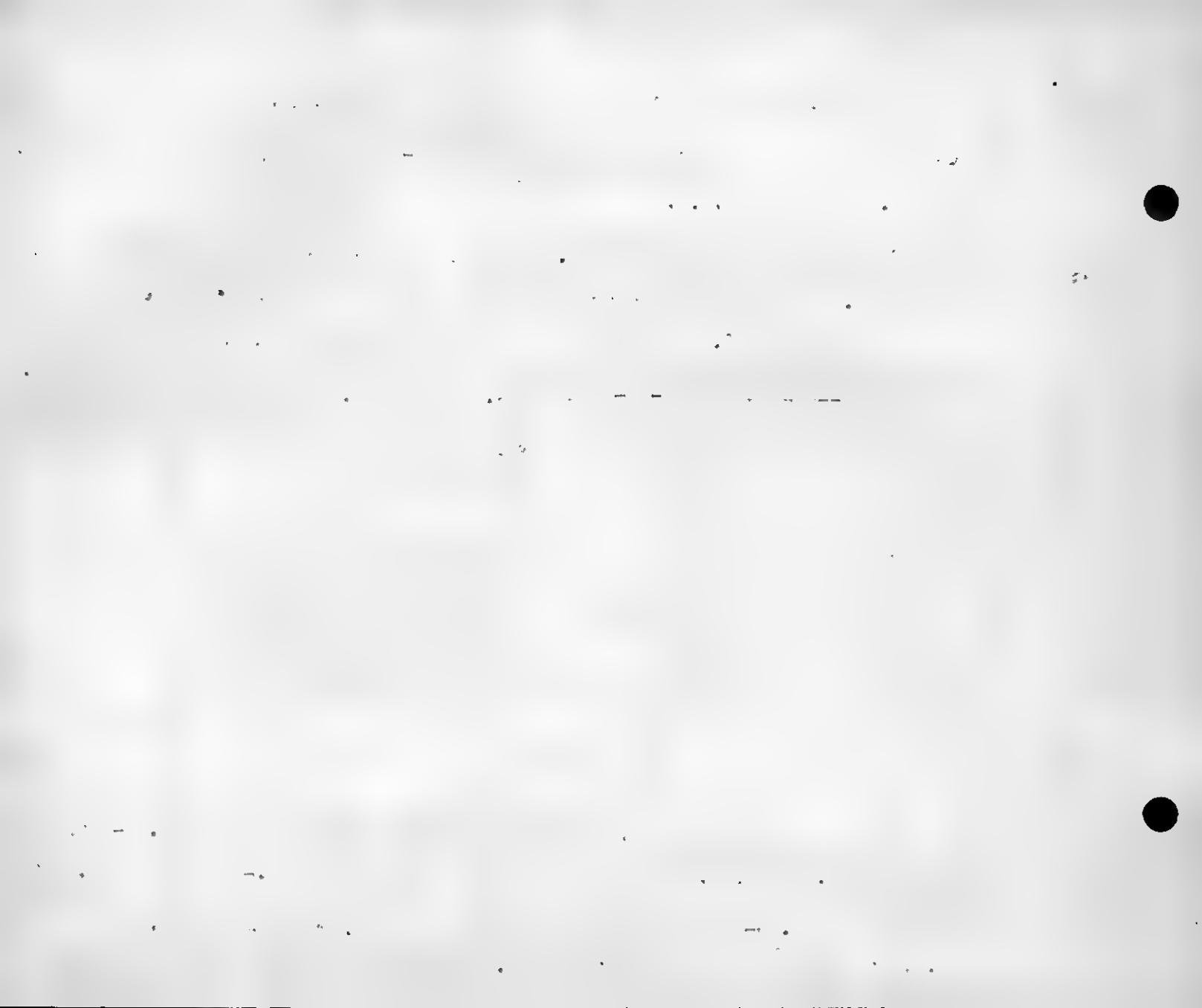
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14393

## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First Edward		Middle Frank	Lost Burke	2a. DATE OF DEATH October Month 2 Day 68 Year		2b. HOUR 12:45	
3. SEX Male		4. RACE White		5. DATE OF BIRTH July 16- 1928		6. AGE (In years last birthday) 40 YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Frederick Md.			
10. CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Mem. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Operator - Musician		12b. KIND OF BUSINESS OR INDUSTRY Music Store			
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE Md.		13b. COUNTY Frederick		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2 Clarke Place	
14. FATHER'S NAME First Edward		Middle T.		Lost Burke		15. MOTHER'S MAIDEN NAME First Clora		Middle Augusta	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		(If yes, give war or dates of service)		16b. SOCIAL SECURITY NO 218-24-9921		17. INFORMANT 2 Clarke Place Address Frederick, Md. Mrs. Patricia A. Stonestreet Burke			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) <u>5 days</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>9/28, 1968</u> to <u>10/2, 1968</u> , that (I) (we) lost saw the deceased alive on <u>10/2, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Robert S. Hughes</u>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Oct. 3-1968			
22d. PHYSICIAN'S NAME (Type) Dr. Robert S. Hughes		22e. ADDRESS 700 Montclair Ave.-Frederick, Md. 21701							
23a. BURIAL CREMATION, REMOVING (Specify) BURIAL		23b. DATE Oct. 4-1968		23c. NAME OF CEMETERY OR CREMATORY Providence Cemetery		23d. LOCATION (City or Town) Kempstown-		(County) (State) Maryland	
24. FUNERAL DIRECTOR M.R. Etchison & Son		ADDRESS Elwood T. Whitmore Frederick, Md. 21701		25a. REC'D BY REGISTRAR DATE OCT 7 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
14387										
14394										
1 DECEASED NAME (Type or print)					2a. DATE OF DEATH		2b. HOUR			
First Crystal					Middle Lee		Last Burkle		October 27, 1968	
3. SEX		4. RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		7. UNDER 1 YEAR		
Female		White		September 10, 1901		67 YRS.		MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		Md.		
Arkansas		U.S.A.				Frederick.				
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
Frederick		Frederick Memorial Hosp.		Homemaker		None				
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland		Frederick		Frederick				1701 West 7th Street		
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Nicholas			Middle Cyrus			Last Kizer				
First Eula			Middle Luckey			Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b SOCIAL SECURITY NO			17 INFORMANT				
No			216-30-2469			Mr. Kenneth K. Burkle 1701 W. 7th St. Fred. Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>myocardial infarction &amp; shock</u>									1 day	
4109 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
DUE TO, OR AS A CONSEQUENCE OF (b)										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
<u>LUL pneumonia</u> <u>rheumatoid arthritis</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		HOUR A.M. Month Day Year								
		P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No.		City or Town		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <u>27 Oct</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>27 Oct</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					ATTENDING PHYS		22c. DATE SIGNED			
<u>George I. Smith Jr.</u> M.D.					<input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		<u>27 Oct 68</u>			
22d PHYSICIAN'S NAME (Type)					22e ADDRESS					
Dr. George I. Smith, Jr., M.D.					804 Toll House Avenue Frederick, Md.					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County) (State)		
Removal-Burial		10-29-1968		Oakland Cemetery		Monticello, Drew, Arkansas				
24 FUNERAL DIRECTOR					25a REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Robert E. Dailey & Son Frederick, Maryland					DATE <u>OCT 31 1968</u>		<u>Charles Judge</u>			





## CERTIFICATE OF DEATH

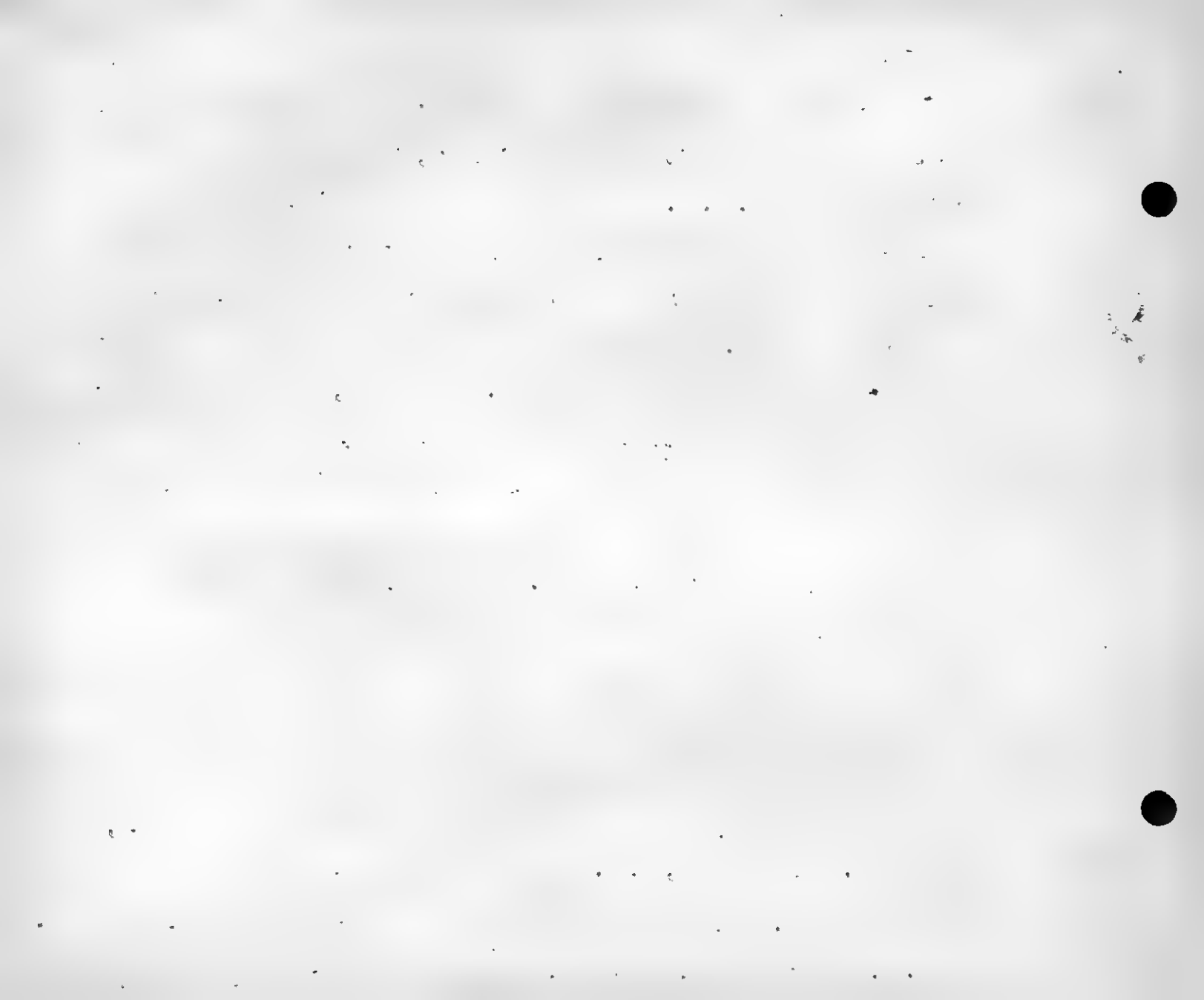
14395

14388

1 DECEASED-NAME (Type or print) <b>JOHN</b> First <b>RAYMOND</b> Middle <b>CORUN, SR.</b> Last			2a DATE OF DEATH Month <b>October</b> Day <b>8</b> Year <b>1968</b>			2b HOUR <b>9 A</b> M				
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>July 27, 1889</b>		6 AGE (in years last birthday) <b>79</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Frederick</b> Md.				
10 CITY OR TOWN OF DEATH <b>Jefferson</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Jefferson, Maryland</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired</b>			12b KIND OF BUSINESS OR INDUSTRY <b>B &amp; O Railroad</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) - STATE <b>Maryland</b>			13b. COUNTY <b>Frederick</b>		13c CITY OR TOWN <b>Jefferson</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Jefferson, Maryland</b>	
14 FATHER'S NAME First <b>Albert</b> Middle <b>F.</b> Last <b>Corun</b>			15. MOTHER'S MAIDEN NAME First <b>Frances</b> Middle <b>Jennings</b> Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)			16b SOCIAL SECURITY NO		17 INFORMANT Address <b>Mrs. Edith Corun, Jefferson, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Decompensation</b> <b>1945</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Bronchitis &amp; Emphysema</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Advanced generalized arteriosclerosis</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21a. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>10/1, 1967</b> to <b>10/8, 1968</b> , that (I) (we) lost the deceased alive on <b>10/8, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>A. Talbott Brice</b> DEGREE						ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>Oct. 9, 1968</b>		
22d. PHYSICIAN'S NAME (Type) <b>A. Talbott Brice, M. D.</b>						22e. ADDRESS <b>Jefferson, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>Oct. 11, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Jefferson Frederick Md.</b>			
24. FUNERAL DIRECTOR <b>Donald M. Etchison &amp; Son, Frederick, Maryland</b>						25a. REC'D BY REGISTRAR DATE <b>OCT 14 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



14389

## CERTIFICATE OF DEATH

14396

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED-NAME (Type or print) <b>MILLIE VIRGINIA CULLER</b>			2a. DATE OF DEATH Oct. Month 10 Day 1968 Year			2b. HOUR 7:45 <sup>AM</sup>	
3 SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>April 12, 1883</b>		6. AGE (In years last birthday) <b>85</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Frederick</b> Md.	
10. CITY OR TOWN OF DEATH <b>Frederick</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Fred. Nursing Center</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Res. before admission) <b>Maryland</b>		13b. COUNTY <b>Frederick</b>		13c. CITY OR TOWN <b>Walkersville</b>		13d. INSIDE CITY, LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>Frederick</b>		14. FATHER'S NAME First Middle Last <b>Daniel Milton Culler</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Catherine Rebecca Horine</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b>		16b. SOCIAL SECURITY NO. <b>212-24-6320</b>		17. INFORMANT Address <b>Miss Edna Culler, Walkersville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerotic hypertensive CVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4201</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b> <b>15 years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Chronic glomerulonephritis and nephrosclerosis</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 19 <b>50</b> , to <b>10/10</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10/10</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE <b>James E. Stoner, Jr.</b> MD		DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10/10/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>JAMES E. STONER, JR.</b>		22e. ADDRESS <b>Walkersville, Md. 21793</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/12/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Luke's Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Frederick Md.</b>	
24. FUNERAL DIRECTOR <b>S. C. Barton, 40 Fulton Ave, Walkersville, Md.</b>		ADDRESS <b>Md.</b>		25a. REC'D BY REGISTRAR/ DATE <b>OCT 14 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14397

14390

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED-NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN <input checked="" type="checkbox"/> Month Day Year			2b HOUR
Lawrence Sylvester Cutsail- Sr.						OF ESTI- DEATH MATED <input type="checkbox"/> Oct. 21- 1968			11: M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD Month Day Year	2d HOUR
Male	White	Nov. 27-1910	57 YRS.					Oct. 21 19 68	11: M
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Md.	U.S.A.			Frederick			Md		
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b KIND OF BUSINESS OR INDUSTRY				
Frederick	809 E. South St.		Station Attendant		Gas Station				
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b COUNTY	13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER	
Md.			Frederick	Frederick		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Route 10	
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First Middle Last
Harvey S. Cutsail						Bertha Bussard			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go on, or unknown)			16b SOCIAL SECURITY NO		17 INFORMANT				ADDRESS
NO			214-14-6711		Mrs. Mabel M. Cutsail-Route 10-Frederick-Md.				
18 CAUSE OF DEATH (Enter only one cause per line, for (a), (b) and (c). PART 1 DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Coronary Artery Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		22b. DATE SIGNED		CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type)		Dr. Robert J. Thomas		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
				ADDRESS (Street, city, town, or county) Frederick-Md.					
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Oct. 24-1968		Rest Haven Mem. Gardens		N. of Frederick, Md. 21701			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
M.R. Etchison & Son		Frederick, Md. 21701		OCT 24 1968		Charles Judge			



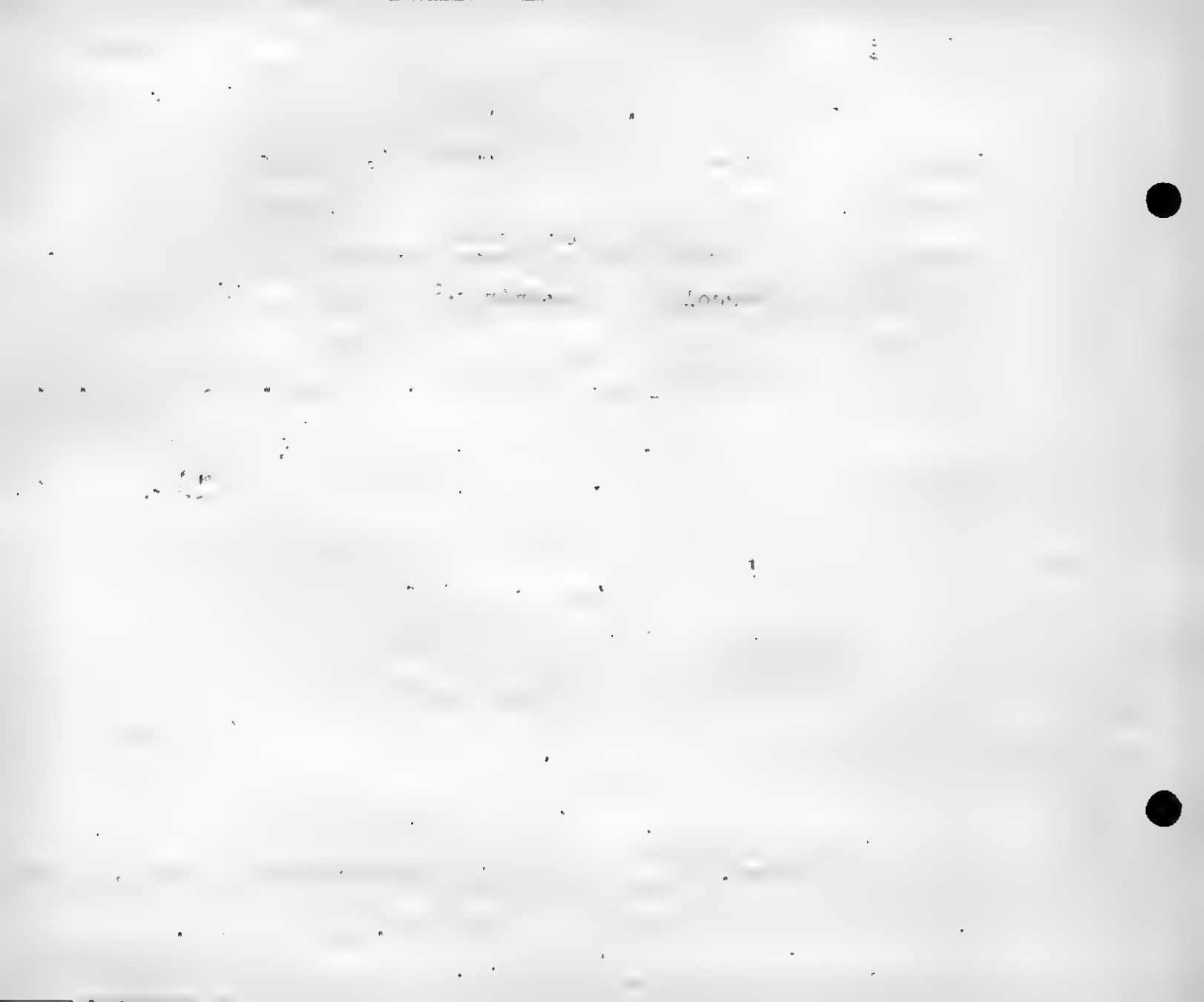


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove above labels. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR ATS  
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) <b>May E. Danner</b>			2a. DATE OF DEATH Month <b>10</b> Day <b>2</b> Year <b>68</b>			2b. HOUR <b>6:15AM</b>					
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>February 12, 1882</b>		6 AGE (In years last birthday) <b>86</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a BIRTHPLACE (State or foreign country) <b>Frederick, Md.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Frederick</b> Md					
10. CITY OR TOWN OF DEATH <b>Frederick</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Frederick Nursing Center</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>house wife</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>					
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b COUNTY <b>Carroll</b>		13c CITY OR TOWN <b>Westminster</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <b>RD 2</b>			
14 FATHER'S NAME First <b>Noah</b> Middle <b>Hill</b> Last <b>Hill</b>			15. MOTHER'S MAIDEN NAME First <b>Unknown</b> Middle <b>Unknown</b> Last <b>Unknown</b>								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>214-51-0061</b>		17. INFORMANT Address <b>George L. Danner, Sr. Thurmont, Md. Rt. 1</b>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4109</b> (b) <b>Arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic heart disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Essential Hypertension</b>											
19a DATE OF OPERATION <b>3/25/68</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cholecystitis</b>		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>3/25/68</b> to <b>10/2/68</b> , that (I) (we) last saw the deceased alive on <b>10/2/68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <b>Frank Damazo, MD</b>		22c DATE SIGNED <b>10/3/68</b>		22d PHYSICIAN'S NAME (Type) <b>Frank Damazo, MD</b>		22e ADDRESS <b>700 Montclair Avenue, Frederick, Maryland</b>					
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE <b>10/1/68</b>		23c NAME OF CEMETERY OR CREMATORY <b>Knoxville Reform Cem. Knoxville, Md.</b>		23d LOCATION (City or Town) (County) (State) <b>Thurmont, Md.</b>					
24 FUNERAL DIRECTOR <b>Raymond E. Greager</b>		25a REC'D BY REGISTRAR <b>Charles Judge</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>OCT 7 1968</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
14392														
14399														
CERTIFICATE OF DEATH														
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR					
Claude			Andrew Delauter			Oct 28 1968			11:50 AM					
3 SEX		4 RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Male		Colored		6-16-1881			87 YRS.		MONTHS DAYS		HOURS MIN			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH			Md.		
Maryland			U.S.A.			Frederick								
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
Frederick			Frederick Memorial General Utilities			HOTEL								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER		
Md			Frederick			Frederick			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			32 S. COURT STREET		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
First Middle Last			First Middle Last											
UNKNOWN			ANNIE			NMA DELAUTER								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17 INFORMANT			Address					
NO			214-10-2258			Mrs Bertha Delauter			32 S. COURT ST					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														
PART 1. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) Acute myocardial infarction														
4109 DUE TO, OR AS A CONSEQUENCE OF														
(b) Acute coronary thrombosis														
DUE TO, OR AS A CONSEQUENCE OF														
(c) Atherosclerotic Heart Disease														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
726														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
			HOUR A.M. Month Day Year P.M. 19											
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State								
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>														
22a. I certify that (I) (this hospital) attended the deceased from Oct 18, 1968, to Oct 28, 1968, that (I) (we) last saw the deceased alive on Oct 28, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE			22c. DATE SIGNED											
Henry V. Chase			10/28/68											
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS											
Henry V. Chase			204 Toll House Frederick Md											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			10-31-1968			Fairview			Frederick Fred, Md					
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
C. E. Hicks			Frederick, Md			OCT 31 1968			Charles Judge					

MEDICAL CERTIFICATION



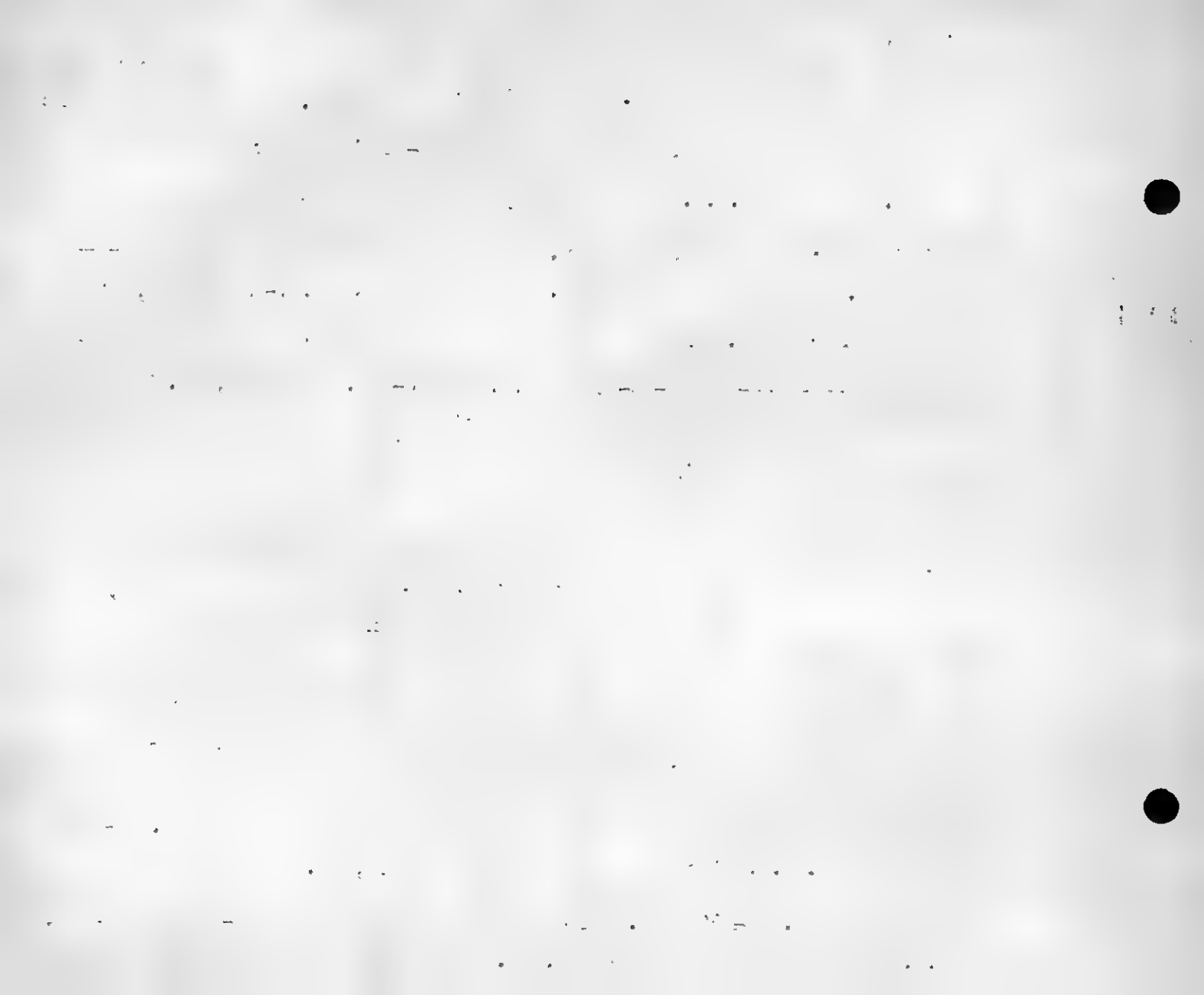


1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print)		First Rhea		Middle S.		Last Diller		2a. DATE OF DEATH Oct. Month 12 Day 68 Year		2b. HOUR 12:35M
3. SEX Female		4. RACE White		5. DATE OF BIRTH June 17- 1897		6. AGE (In years last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Frederick Md.				
10. CITY OR TOWN OF DEATH Braddock Hgts.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Vindobona Conv. & Rest Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Frederick		13c. CITY OR TOWN Nr. Jefferson		13d. INSIDE CITY LIM TSP YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER P.O.- Jefferson, 21755		
14. FATHER'S NAME First Middle Last Benjamin M. Smith				15. MOTHER'S MAIDEN NAME First Middle Last Roberta Eyler						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		(If yes give war or service)		16b. SOCIAL SECURITY NO. 220-16-7228		17. INFORMANT Address E.W. Mottern- Nr. Jefferson, Md. 21755				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mitastatic Carcinoma</u> 1841 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>1750</u> (b) <u>Carcinoma Throat</u> DUE TO, OR AS A CONSEQUENCE OF (c)										<u>6 mo</u> <u>4 yrs</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Myocardial decompensation</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>May 6, 19</u> , to <u>Oct 12, 1968</u> , that (I) (we) last saw the deceased alive on <u>Oct 12, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>A.T. Brice</u>		DEGREE Dr. A.T. Brice		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Oct. 13-1968				
22d. PHYSICIAN'S NAME (Type) Dr. A.T. Brice		22e. ADDRESS Jefferson, Md. 21755								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct. 15-1968		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Frederick- Frederick- Md.				
24. FUNERAL DIRECTOR M.R. Etchison & Son		ADDRESS Elwood T. Whitmore Frederick, Md.		25a. REC'D BY REGISTRAR DATE OCT 16 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				



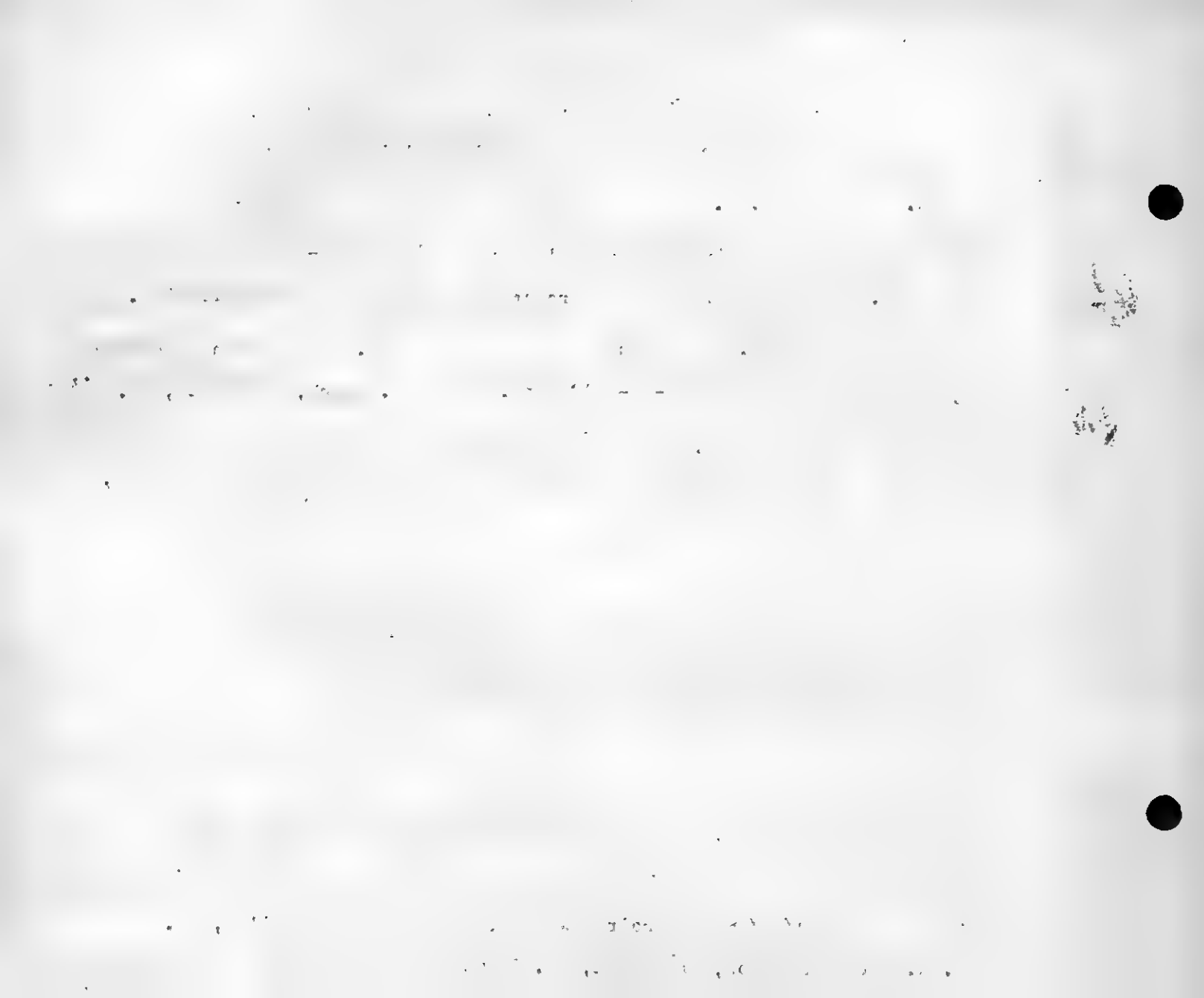
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print) <b>Lillian</b> First <b>Hahn</b> Middle <b>Doan</b> Last					2a. DATE OF DEATH <b>Oct.</b> Month <b>20</b> Day <b>1968</b> Year			2b. HOUR <b>10:30</b> M		
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>30 April 1889</b>		6. AGE (In years last birthday) <b>79</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS M.N.		
7a. BIRTHPLACE (State or foreign country) <b>Pa.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		8- MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Frederick</b> Md.				
10. CITY OR TOWN OF DEATH <b>Frederick</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Frederick Memorial Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>House-work</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Frederick</b>		13c. CITY OR TOWN <b>Frederick</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>303 Magnolia Ave.</b>	
14. FATHER'S NAME First <b>John</b> Middle <b>D.</b> Last <b>Hahn</b>			15. MOTHER'S MAIDEN NAME First <b>V.</b> Middle <b>Lillian</b> Last <b>Dodamead</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <b>220-44-6110</b>		17. INFORMANT <b>Mrs. Hester D. Trunk, 303 Magnolia Ave., Frederick, Md. 21701</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>4124</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio-sclerotic C.V.D. (with pulmonary edema)</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>10 days</b>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 5</b> , 19 <b>66</b> , to <b>Oct. 20</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Oct. 20</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Bernard O. Thomas Jr.</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. DATE SIGNED <b>Oct. 20, 1968</b>										
22d. PHYSICIAN'S NAME (Type) <b>Bernard O. Thomas Jr.</b>				22e. ADDRESS <b>Frederick, Maryland</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/23/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Coatesville, Pa.</b>				
24. FUNERAL DIRECTOR <b>M. R. Etchison &amp; Son, Frederick, Md. 21701</b>					25a. REC'D BY REGISTRAR <b>OCT 24 1968</b> DATE		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

MEDICAL CERTIFICATION



FOR STATE  
HEALTH DEPT.

TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14395

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 2a  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14402

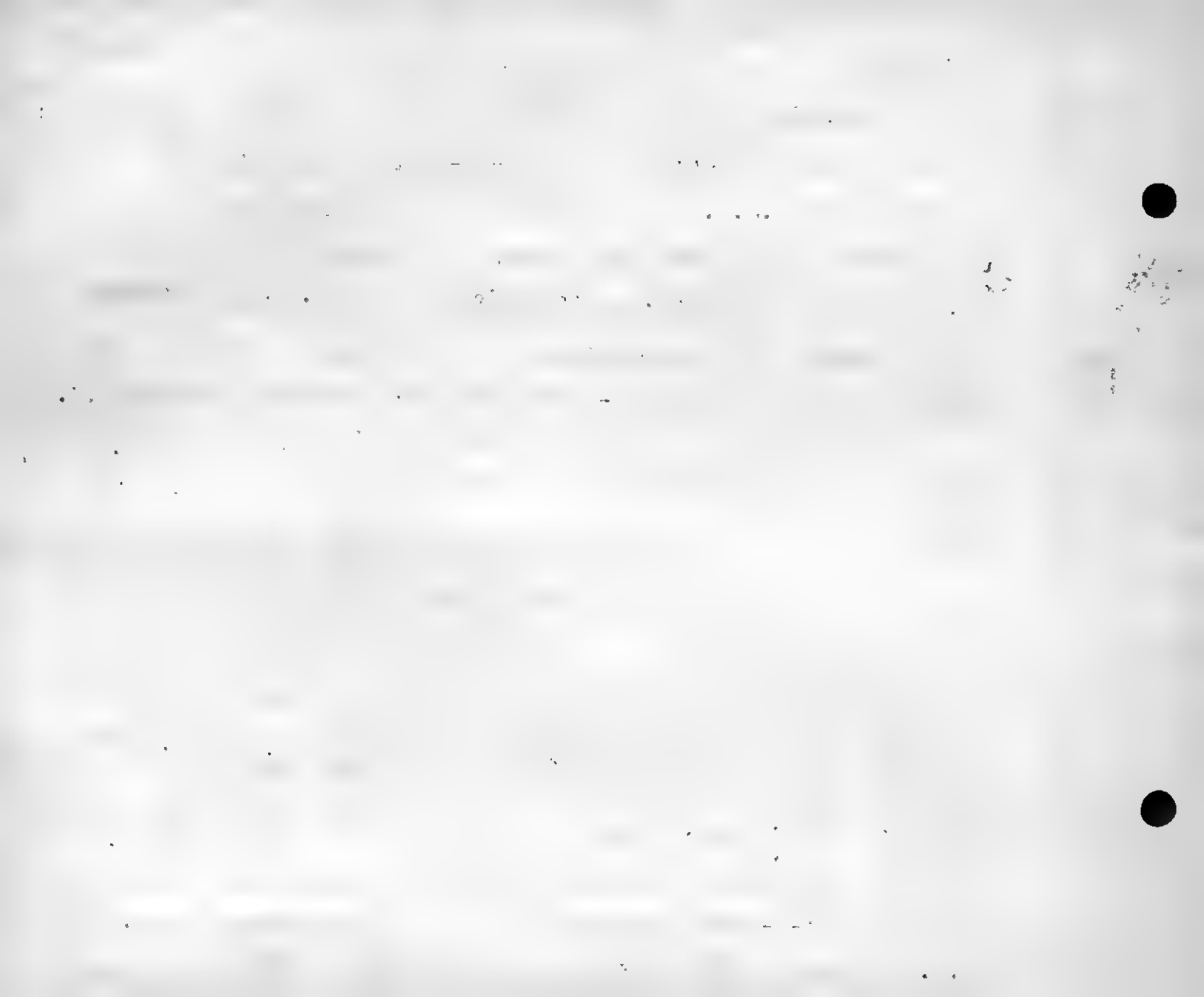
1. DECEASED NAME (Type or Print)			First <b>ANTHONY</b>			Middle <b>JOE</b>			Last <b>DOWNIN</b>			2a. DATE KNOWN OF DEATH MATED <input type="checkbox"/> Month <u>10</u> Day <u>4</u> Year <u>1968</u>			2b HOUR <u>M</u>				
3 SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Aug. 31, 1962</b>		6 AGE (In years last birthday) <b>6</b> YRS		IF UNDER 1 YEAR MONTHS <u>  </u> DAYS <u>  </u> HOURS <u>  </u> MIN. <u>  </u>		IF UNDER 24 HRS. MONTHS <u>  </u> DAYS <u>  </u> HOURS <u>  </u> MIN. <u>  </u>		2c. DATE PRONOUNCED DEAD Month <u>10</u> Day <u>4</u> Year <u>1968</u>			2d HOUR <b>8 AM</b>				
7a. BIRTHPLACE (State or foreign country) <b>Penna.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <b>Frederick</b> Md							
10. CITY OR TOWN OF DEATH <b>Frederick</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>RD # 1</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) <b>---</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>---</b>							
13a. USUAL RESIDENCE (Where deceased lived, if not in hospital, residence before admission) STATE <b>Md.</b>				13b. COUNTY <b>Frederick</b>				13c. CITY OR TOWN <b>Frederick</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>RD # 1</b>					
14. FATHER'S NAME First <b>Ronald</b> Middle <b>Downin</b> Last <b>Downin</b>						15. MOTHER'S MAIDEN NAME First <b>Barbara</b> Middle <b>Shoop</b> Last <b>Shoop</b>													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16b. SOCIAL SECURITY NO <b>---</b>				17. INFORMANT ADDRESS <b>Ronald Downin, RD # 1, Frederick, Md.</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>suffocation, smoke inhalation</u> <b>890X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>  </u>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>  </u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>116C</b>																			
19a. DATE OF OPERATION <u>  </u>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>  </u>								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month Day, Year HOUR <u>7:15 AM</u> <u>10-4 1968</u>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>HOUSE FIRE</b>											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>HOME</b>				21f. LOCATION Street or RFD No <b>RD1</b>				City or Town <b>FREDERICK</b>				County <b>FREDERICK</b>		State <b>MD.</b>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <u>Robert R. Roberts</u>				M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <u>10-4-68</u>							
EXAMINER'S NAME (Type) <b>ROBERT R. R. ROBERTS, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county) <b>FREDERICK, MD. 21701</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE <b>10/6/1968</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Harbaugh's Cemetery</b>				23d. LOCATION (City or Town) (County) (State) <b>Franklin County, Pa.</b>							
24. FUNERAL DIRECTOR <u>S. Martin Poe</u>				ADDRESS <b>Waynesboro, Penna. 17268</b>				25a. REC'D BY REGISTRAR <b>OCT 7 1968</b>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 13 Film 406 11/7/68										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										14403																					
14396										CERTIFICATE OF DEATH																															
1. DECEASED NAME (Type or print) First Middle Last <b>Maggie NMN Ford</b>										2a. DATE OF DEATH Month Day Year <b>October 30 1968</b>										2b. HOUR <b>7:45</b>																					
3. SEX <b>Female</b>										4. RACE <b>Negro</b>										5. DATE OF BIRTH <b>9-10-1875</b>										6. AGE (in years last birthday) <b>93</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS AM PM									
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>										7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH <b>Frederick</b>		Mo.									
10. CITY OR TOWN OF DEATH <b>Frederick</b>										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Montevue Co Home</b>										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Domestic</b>										12b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>											
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MD</b>										13b. COUNTY <b>Fred.</b>										13c. CITY OR TOWN <b>Frederick</b>										13d. INSIDE CITY, Y.M. IS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>400 Middle Alley</b>		13f. <b>W 14th St Extended</b>							
14. FATHER'S NAME First Middle Last <b>Dennis NMN Chambers</b>										15. MOTHER'S MAIDEN NAME First Middle Last <b>Susie Unkn Unkn</b>																															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>										16b. SOCIAL SECURITY NO <b>219-54-0760</b>										17. INFORMANT <b>Ethel Ford</b>										Address <b>11 Sylvan Terrace N.Y.</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b> <b>10 years</b>																																									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>420</b>																																									
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																					
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 1962</b> to <b>Oct 30, 1968</b> , that (I) (we) last saw the deceased alive on <b>Oct 30, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																									
22b. SIGNATURE <b>Le Roy T Davis</b>										DEGREE <b>MD</b>										ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED <b>10/30/68</b>											
22d. PHYSICIAN'S NAME (Type) <b>C.E. Hicks</b>										22e. ADDRESS <b>111 Frederick, Md</b>																															
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>										23b. DATE <b>11-2-1968</b>										23c. NAME OF CEMETERY OR CREMATORY <b>Fairview</b>										23d. LOCATION (City or Town) (County) (State) <b>Frederick Fred. Md</b>											
24. FUNERAL DIRECTOR <b>C.E. Hicks</b>										24a. ADDRESS <b>111 Frederick, Md</b>										25a. REC'D BY REGISTRAR <b>NOV 4 1968</b>										25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>											





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 5-41  
30M REL 1-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14397

14404

1. DECEASED NAME (Type or print) First Middle Last EMORY WALTER FULTON			2a. DATE OF DEATH Month Day Year October 13 1968		2b. HOUR P. 11:05 M
3. SEX Male		4. RACE White	5. DATE OF BIRTH May 27, 1890 <del>November 18, 1889</del>		6. AGE (In years last birthday) 78 YRS.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Frederick Md.
10. CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Frederick	13c. CITY OR TOWN Point of Rocks	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Point of Rocks, Md.
14. FATHER'S NAME First Middle Last William Fulton			15. MOTHER'S MAIDEN NAME First Middle Last Emma Oden		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		16b. SOCIAL SECURITY NO. A 625293		17. INFORMANT Address Fred Fulton, Marietta, Georgia	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>sub-occluded myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic cardiac vascular changes</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>20 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>4-20</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>arteriosclerosis obliterans @ leg</u>					
19a. DATE OF OPERATION 9 Oct 68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED gangrene @ leg		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>24 Sept, 1968</u> , to <u>13 Oct, 1968</u> , that (I) (we) last saw the deceased alive on <u>13 Oct, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>G. I. Smith</u>		22c. DATE SIGNED 14 Oct 68		22d. PHYSICIAN'S NAME (Type) G. I. Smith, M.D.	
22e. ADDRESS Toll House Ave. Frederick, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct. 17, 1968	23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		23d. LOCATION (City or Town) (County) (State) Pt. of Rocks Frederick Md.
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR OCT 17 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

Toll Ho

Yes W.W.#1 Fred W.W.

William Wilton

Maryland Frederick Point of R

Frederick Memorial Hosp  
U.S.A.  
x

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14398

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14405

1. DECEASED NAME (Type or print) <b>Franklin Elias Gaver</b>			2a. DATE OF DEATH Month <b>October</b> Day <b>5</b> Year <b>1968</b>			2b. HOUR <b>1 p m</b>				
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>February 4, 1887</b>		6 AGE (in years last birthday) <b>81</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Frederick,</b> Md.				
10 CITY OR TOWN OF DEATH <b>Rural Ladiesburg</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Rural Ladiesburg</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Farming</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Frederick</b>		13c. CITY OR TOWN <b>Ladiesburg</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Edgewood Spring Farm</b>	
14 FATHER'S NAME First <b>Philip</b> Middle <b>Franklin</b> Last <b>Gaver</b>			15 MOTHER'S MAIDEN NAME First <b>Anna</b> Middle <b>E.</b> Last <b>Hooper</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, on, or unknown) <b>No</b> (If yes give year or dates of service)			16b. SOCIAL SECURITY NO. <b>220-34-0867</b>		17. INFORMANT Address <b>Mr. Paul E. Gaver 517 N. Market St. Fred. Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4301</b> (b) <b>Hypertensive CVD with congestive myocardial failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>15 years</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 min</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Pulmonary emphysema &amp; chronic bronchitis</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased <b>from March, 1959, to 5 Oct, 1968</b> , that (I) (we) last saw the deceased alive on <b>5 October 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>do not</del> ) view the body after death.										
22b. SIGNATURE <b>James E. Stoner, Jr. MD</b> DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10/5/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>Dr. James E. Stoner, Jr. M.D.</b>						22e. ADDRESS <b>WALKERSVILLE, Md. 21793</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>10-8-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Frederick, Frederick, Md.</b>		
24. FUNERAL DIRECTOR <b>Robert E. Dailey &amp; Son</b> ADDRESS <b>Frederick, Md.</b>						25a. REC'D BY REGISTRAR <b>OCT 10 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VA 11-1  
30M REV. 1-58

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
14399									
14406									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Rex Euther Green						Oct. 3 1968		11:20	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR	
male		white		5-12-1892		76 YRS.		MONTHS DAYS HOURS M.N.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Maryland		USA				Frederick			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Frederick		Frederick Memorial Hosp.		Carpenter		Mill			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Fred.		Sabillasville					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
George B. Green			Florence Virginia Lewis						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT Address				
No			217-10-9189		Thomas C. Green Thurmont, Md. RD 2				
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))									
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Jaundice									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF (b) Common Bile Duct Obstruction									
DUE TO, OR AS A CONSEQUENCE OF (c) Gall Stones									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
584X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 9/2/68, 19, to 10/3/68, 19, that (I) (we) last saw the deceased alive on 10/3/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
A. Austin Pearce Jr.							10/4/68		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
A. Austin Pearce Jr. 804					Toll House Ave. - Frederick, Md.				
23a. BURIAL, CREMATION, OR OTHER DISPOSITION		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		10-6-68		Mt. Bethel Meth. Cem.		Foxville Fred. Co. Md.			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Raymond E. Creager					DATE OCT 8 1968		J. Charles Judge		
Thurmont, Md.									



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14400

14407

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PK-10. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year		2b HOUR
CORA		A.		GRIMES	10/1/1968		M
3 SEX	4 RACE	5. DATE OF BIRTH		6 AGE (in years or birthday)	7 UNDER YEAR MONTHS DAYS	2c. DATE PRONOUNCED DEAD Month Day Year	
Female	White	3/18/1905		63 YRS		Oct. 1, 1968 ? M	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH	
Maryland		U.S.A.				Frederick Md	
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Frederick		Frederick Mem. Hospital		Housewife			
13a U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b COUNTY		13c. CITY OR TOWN		13d INSIDE CITY YN TS?	
Maryland		Carroll		Mt. Airy		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
						13e. STREET AND NUMBER	
						R. D. 4	
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First Middle Last
Irvin				Harrison	Effie		M. Ridgley
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		None		Roy W. Grimes		Same As #13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Transsected Brain Stem</u> 519.7 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost } (b) <u>Broken Neck</u> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>800.1</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
		10-1-1968		Auto accident			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or RFD No City or Town County State			
		Rte 40 Highway		Twin Arch Rd.		Howard Md.	
22a. I certify that I took charge of the remains described above, held on death resulted from: Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASS STANT MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED	
EXAMINER'S NAME (Type)		Dr. Robert J. Thomas Frederick, Md.		DEPUTY MED CAL EXAMINER <input checked="" type="checkbox"/>		Oct. 1, 1968	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		10/5/1968		Mt. Olive		Carroll, Md.	
24 FUNERAL DIRECTOR ADDRESS				25a REC'D BY REGISTRAR DATE		25b REGISTRAR'S SIGNATURE	
C. M. Waltz, Box 241, Sykesville, Md.				OCT 4 1968		Charles Judge	





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the original. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14408

1 PLACE OF DEATH a COUNTY <u>FREDERICK</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>FREDERICK</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>THURMONT RURAL MINUTES</u>		c LENGTH OF STAY in 1b <u>THURMONT ROUTE 1</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>TROUTVILLE</u>		d STREET ADDRESS <u>NONE</u>	
3 NAME OF DECEASED (Type or print) <u>ROBERT RADCLIFFE HEWARD SR</u>		4 DATE OF DEATH Month <u>OCT</u> Day <u>9</u> Year <u>1968</u>	
5 SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>AUG 18 - 1940</u>
9 AGE (In years last birthday) yrs <u>28</u>		10 IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>SPREADER</u>		10b KIND OF BUSINESS OR INDUSTRY <u>SEWING FACTORY</u>	
11 BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>RUDOLPH T HEWARD</u>		14 MOTHER'S MAIDEN NAME <u>MARY LANG</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO. <u>220-36-1334</u>	
17 INFORMANT <u>PATSY M HEWARD THURMONT MD</u>		Address <u>RI</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Massive Hemorrhage</u> DUE TO (b) <u>Disruption Liver &amp; Kidney</u> DUE TO (c) <u>Shotgun Wound - Abdomen</u>			INTERVAL BETWEEN ONSET AND DEATH
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) <u>Shuffled while hunting</u>	
20c TIME OF INJURY Month, Day Year <u>8:30 pm 10-9-1968</u>	20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Woods</u>	20f (City or town) (County) (State) <u>Thurmont-Fredrick-Md.</u>
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Clifford B. Lull, Jr., M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>CLIFFORD B LULL JR</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b DATE THEREOF <u>OCT 13 - 1968</u>	
23c NAME OF CEMETERY OR CREMATORY <u>MT HOPE</u>		23d LOCATION (City or Town) (County) (State) <u>WOODSBORO MD</u>	
24 FUNERAL DIRECTOR <u>Powell &amp; Hartzler Woodboro Md</u>		25a REC'D BY REGISTRAR DATE <u>OCT 14 1968</u>	
		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with Medical Examiner

MEDICAL CERTIFICATION

14402										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										14409																								
1. DECEASED-NAME (Type or print) First Middle Last Wilbur Vanburen Hottinger										2a. DATE OF DEATH Month Day Year 10 15 68										2b. HOUR P M 6:35 AM																								
3 SEX Male					4 RACE W					5 DATE OF BIRTH Oct. 9, 1886					6 AGE (In years lost birthday) 82 YRS.					7a. BIRTHPLACE (State or foreign country) West Va.					7b. CITIZEN OF WHAT COUNTRY? USA					8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH Frederick Md.									
10. CITY OR TOWN OF DEATH Frederick										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) DOA Fred. Mem. Hospital										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Carpenter										12b. KIND OF BUSINESS OR INDUSTRY Construction														
13a. USUAL RES. (Where deceased lived, if institution Residence before admission) STATE Maryland										13b. COUNTY Mont.					13c. CITY OR TOWN Derwood					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET AND NUMBER None																			
14 FATHER'S NAME First Middle Last Silas - Hottinger										15. MOTHER'S MAIDEN NAME First Middle Last Anna Ellen Leatherman																																		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no										16b. SOCIAL SECURITY NO. 214-18-2734					17 INFORMANT Earl Hottinger										Address Rockville, Md.																			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIO SCLEROTIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>GENERALIZED ARTERIO SCLEROSIS</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>GENERALIZED ARTERIO SCLEROSIS</u>																																												
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part or Part 2, Item 18.)																																		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No					City or Town					County					State																			
22a. I certify that (I) (this hospital) attended the deceased from <u>1954</u> , 19 <u>  </u> , to <u>OCT 19, 1968</u> , that (I) (we) last saw the deceased alive on <u>OCT 19, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (aid) (do not) view the body after death																																												
22b. SIGNATURE <u>G.F. McA DORS</u> MD										DEGREE					ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>					22c. DATE SIGNED 10/19/68																								
22d. PHYSICIAN'S NAME (Type) G.F. MCA DORS, M.D.										22e. ADDRESS 810 TOLL HOUSE AVE, FREDERICK, MD.																																		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE Oct. 22, 1968					23c. NAME OF CEMETERY OR CREMATORY Flower Hill					23d. LOCATION (City or Town) (County) (State) Redland Mont. Md.																													
24. FUNERAL DIRECTOR Francis H. Barber										ADDRESS Laytonsville, Md.					25a. REC'D BY REG. STRAR DATE OCT 22 1968					25b. REG. STRAR'S SIGNATURE Charles Judge																								



# FOR STATE HEALTH DEPT.

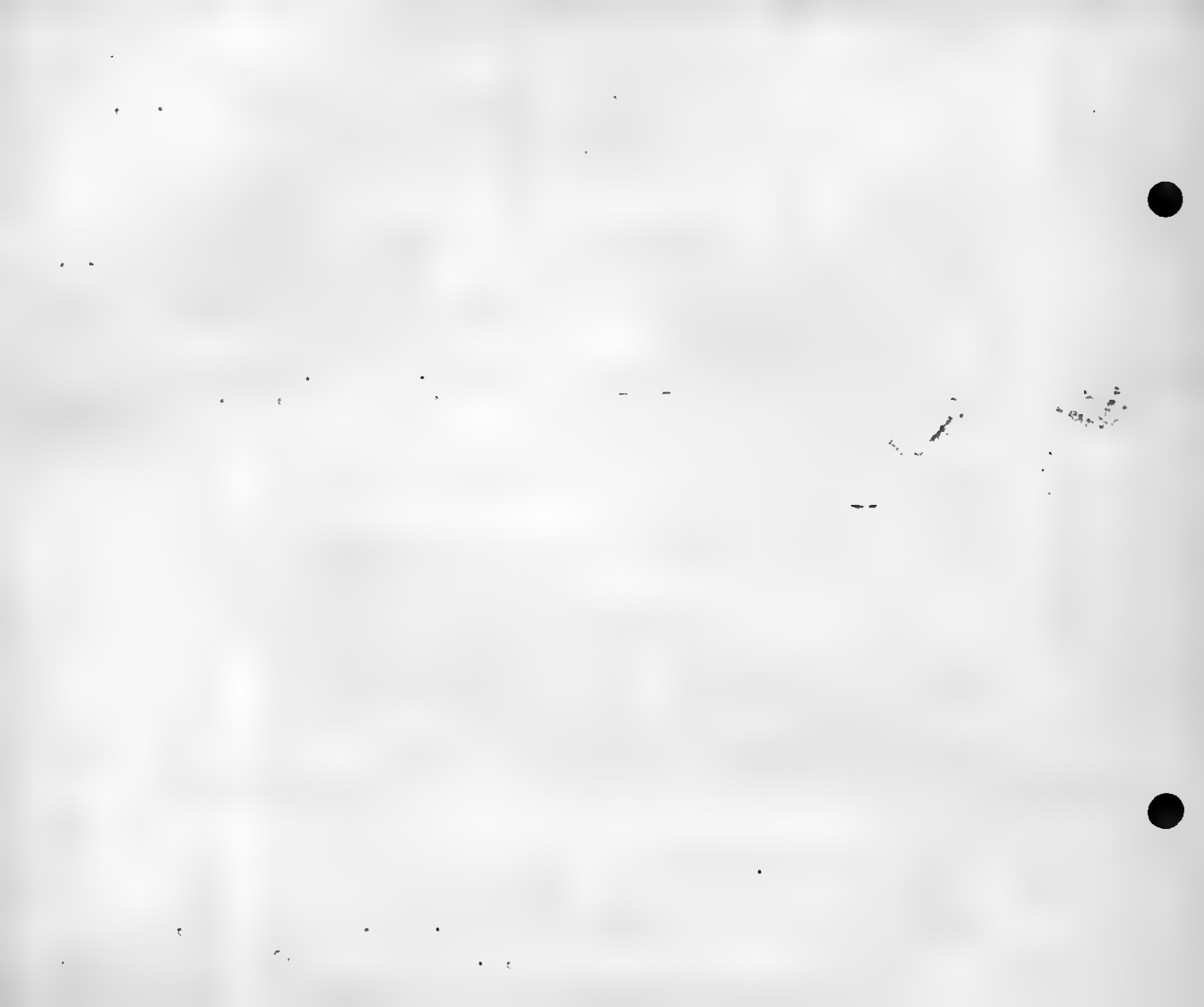
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-11-68-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14410

1 DECEASED NAME (Type or Print)		First M d d l e Last		2a DATE KNOWN OF EST DEATH MATED <input checked="" type="checkbox"/> Month Day Year		2b HOUR	
WILMER		LEROY		HUGHES		Oct. 2, 19 68 M	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (n years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year	2d HOUR
Male	White	June 6, 1918	50 YRS			19 M	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Maryland		USA				Frederick Md.	
1d CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USJAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY	
Frederick (Rural)		US 40 East		Motor Car Repairman		R.R.	
13a USJAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland		Washington		Sandy Hook		Main Street	
14 FATHER'S NAME First M d d l e Last		15 MOTHER'S MAIDEN NAME First Middle Last					
Paul Edward Hughes		Mary Ashbaugh					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17 INFORMANT Mrs. Eva C. Hughes ADDRESS RFD# 2, Knoxville, Md. 21758			
Yes		WW II					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fractured Skull</u> 819.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>8154</u>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		2d AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year HOUR MIN <u>4:40 PM 10-2 1968</u>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>Auto Accident</u>			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Highway</u>		21f LOCATION Street or RFD. No. City or Town County State <u>U.S. RT. 40 Frederick Md</u>			
22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion							
ACTUAL SIGNATURE <u>Robert J. Thomas</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED <u>Oct. 2, 1968</u>	
EXAMINER'S NAME (Type) Robert J. Thomas		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
Burial		10/5/68		Brownsville Hgts. Cem.		Brownsville, Maryland	
24 FUNERAL DIRECTOR <u>F. Donald Eackles</u>		ADDRESS <u>Harpers Ferry, W. Va.</u>		25a REC'D BY REGISTRAR DATE <u>OCT 7 1968</u>		25b REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	



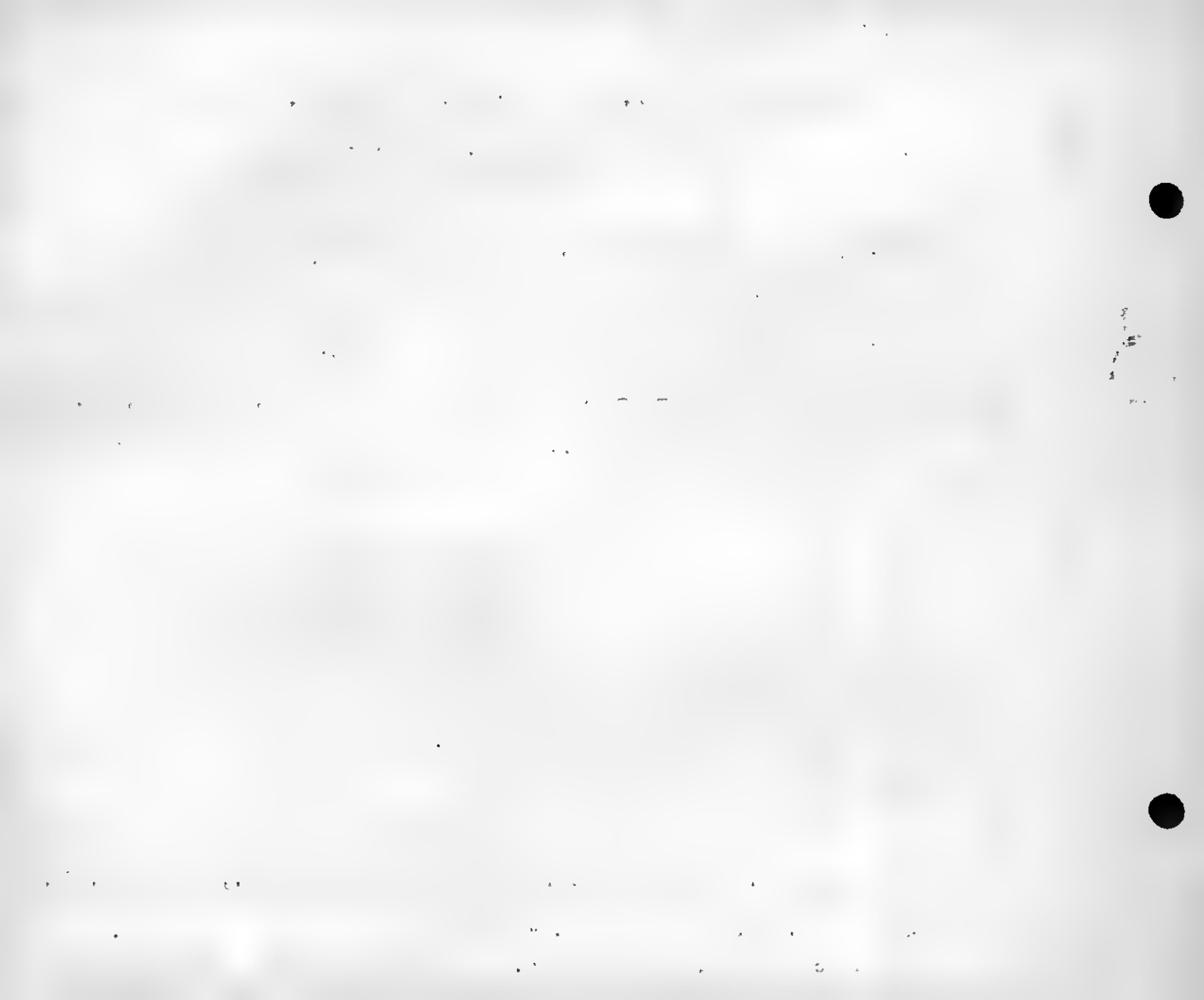
CERTIFICATE OF DEATH

14411

1. DECEASED NAME (Type or print) <b>MURLEY JOSEPH A.</b>		2a. DATE OF DEATH <b>Oct.</b> Month <b>10</b> Day <b>'68</b> eor		2b. HOUR <b>A</b> <b>12:45</b> M	
3. SEX <b>MALE</b>	4 RACE <b>White</b>	5. DATE OF BIRTH <b>May 23, 1899</b>		6. AGE (In years last birthday) <b>69</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Frederick</b> Md.	
10. CITY OR TOWN OF DEATH <b>Frederick</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Frederick Memorial Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Painter</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Monrovia</b>	13d. INSIDE CITY LIM TS? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>RFD # 2</b>
14. FATHER'S NAME First Middle Last <b>Harry Hurley</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Rosie Brown</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <b>220-07-1788</b>		17 INFORMANT Address <b>Mrs Ethel D. Hurley, Monrovia, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>primary hepatitis</b> <b>1000</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>100</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>28 Sept, 1968</b> , to <b>9 Oct, 1968</b> , that (I) (we) last saw the deceased alive on <b>9 Oct 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Cal Smith</b>		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10 Oct 68</b>	
22d. PHYSICIAN'S NAME (Type) <b>GEORGE I. SMITH, JR., M.D.</b>		22e. ADDRESS <b>804 Toll House Ave., Frederick, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Oct. 12, 1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. View</b>		23d. LOCATION (City or Town) (County) (State) <b>Purdum, Md.</b>	
24. FUNERAL DIRECTOR <b>Olin L. Molesworth, Damascus, Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>DATE OCT 14 1968</b>	
				25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR			
John Henry Jackson, Sr						October 12 1968		12:35			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		F. INJOUR 1 YEAR MONTHS DAYS			
Male		Negro		4-26-1897		71 YRS.					
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		Md			
Virginia		U.S.A.				Frederick					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
Frederick		Frederick Memorial Farm		Farm hand		*****					
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER		
Md			Frederick		Dickerson		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rtl Dickerson, Md		
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last
John Henry Jackson						Mary Bell Morris					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			(If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT Address				
no					220-34-2735		Ruby E. Jackson Rtl Dickerson, Md				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>1-68</u> <u>RLC Contract</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or RFD No.		City or Town		County State			
22a I certify that (I) (this hospital) attended the deceased from <u>11 Oct</u> , 19 <u>68</u> , to <u>12 Oct</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12 Oct</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b SIGNATURE <u>Calhoun M.D.</u> DEGREE						ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <u>12 Oct 68</u>			
22d PHYSICIAN'S NAME (Type) <u>George I. Smith</u>						22e ADDRESS <u>804 Toll House Fred. Md</u>					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County) (State)			
Burial		10-15-68		Fairview		Frederick Fred.		Md			
24 FUNERAL DIRECTOR ADDRESS						25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
C.E. Hicks, 111 Frederick, Md						OCT 16 1968		<u>Charles Judge</u>			



FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

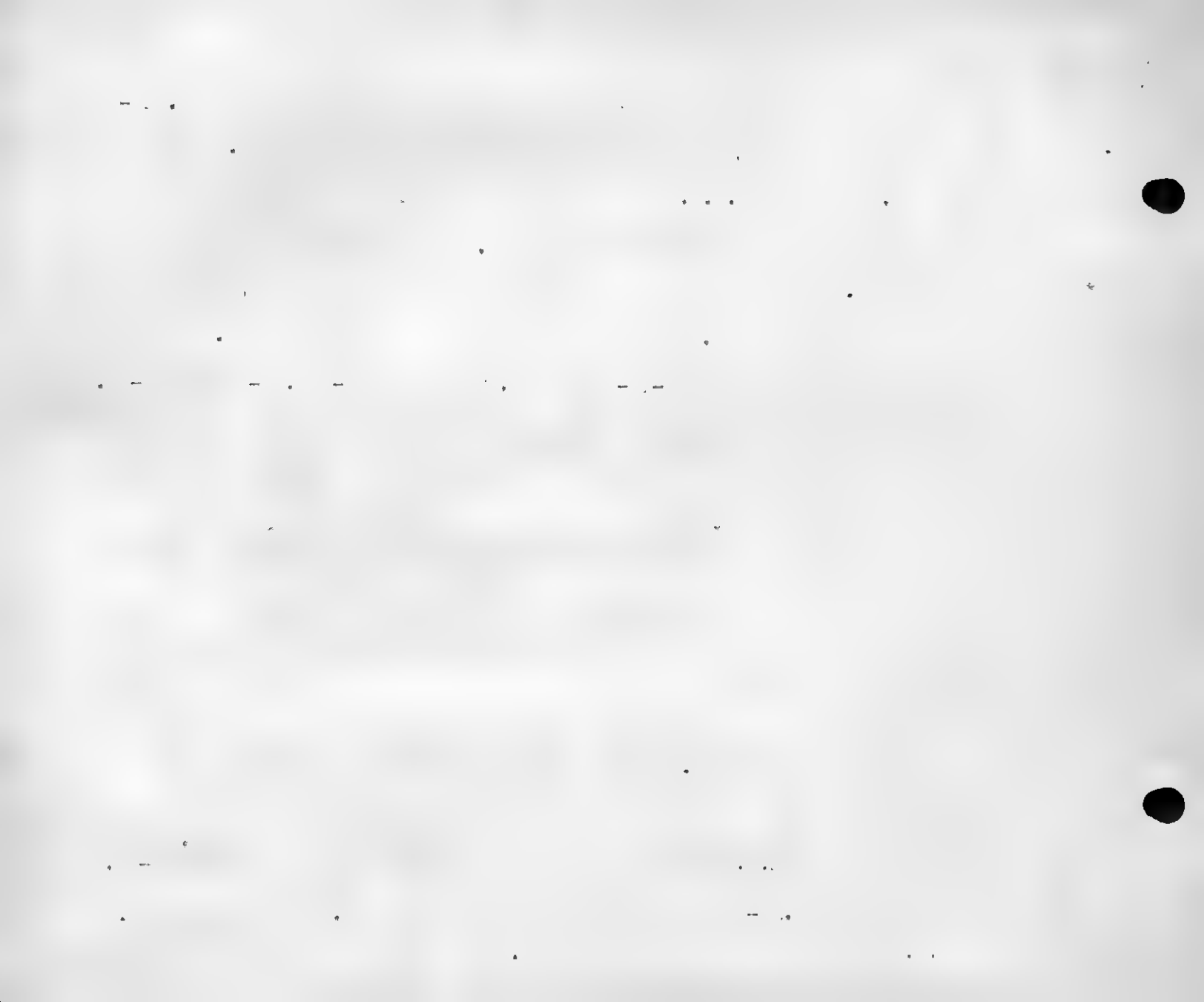
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

14406

14413

1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH ESTIMATED			2b HOUR a		
Garmon Roscoe Linton						Month Day Year			M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD			2d HOUR a
Male	W	Aug. 27, 1922	46 YRS	MONTHS	DAYS	HOURS	MIN	Month Day Year			M
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH					
Md.		U.S.A.				Frederick Md.					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Frederick			230 West Patrick St.			Painter			House		
13a USUA. RESIDENCE (Where deceased lived, if institution adm ssion) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?		
Md.			Frederick			Frederick			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e STREET AND NUMBER			13f ROUTE								
Route 7											
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Roger W. Linton			Frances A. Linton								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT ADDRESS					
Yes			War II			Mrs. Chloe Harris- Rt. 7-Frederick-Md. 21701					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cop Pulmonale</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pulmonary Stenosis, Fibrosis, Bronchiectasis</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION											
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?											
20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
CAUSE OF DEATH			HOUR A.M. P.M.			19					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or RFD No			City or Town County State		
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			ASSISTANT MEDICAL EXAMINER			22b DATE SIGNED		
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town, or county)			Frederick-Md.		
Robert R.R. Roberts									Oct. 16, 1968		
23a BURIAL CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			Oct. 18-1968			Pleasant Hill Cemetery			Nr. Yellow Springs-Md.		
24 FUNERAL DIRECTOR			ADDRESS			25a RECD BY REGISTRAR			25b REGISTRAR'S SIGNATURE		
L.R. Etchison & Son			Whitmore Frederick, Md. 21701			OCT 21 1968			Charles Judge		



**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print) <b>PEARL LOUISE LUCAS</b>					2a DATE OF DEATH Month <b>October</b> Day <b>1</b> Year <b>1968</b>			2b HOUR <b>1:10</b> PM	
3. SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>March 31, 1924</b>		6. AGE (In years last birthday) <b>44</b> YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____ IF UNDER 24 HRS. HOURS _____ MIN _____	
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH <b>Frederick, Md.</b>			
10 CITY OR TOWN OF DEATH <b>Frederick</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Frederick Mem. Hospital</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Nurses Aid</b>		12b KIND OF BUSINESS OR INDUSTRY <b>None</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Frederick</b>		13c. CITY OR TOWN <b>Frederick</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>2 Monroe Avenue</b>	
14. FATHER'S NAME First <b>Joseph</b> Middle <b>Thomas</b> Last <b>Cullen</b>				15. MOTHER'S MAIDEN NAME First <b>Georgia</b> Middle <b>E.</b> Last <b>Myers</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown		16b. SOCIAL SECURITY NO. <b>213-24-9979</b>		17 INFORMANT <b>906 East E Street Brunswick, Maryland</b> <b>Mr. Raymond F. Cullen</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Carcinomatosis secondary to pelvic cancer, probably carcinoma of cervix</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 mo</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No _____ City or Town _____ County _____ State _____					
22a. I certify that (I) (this hospital) attended the deceased from <u>9-1-</u> , 19 <u>68</u> , to <u>10-1-</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>9-30-</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Rex R. Martin M.D.</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>Oct. 1, 1968</b>		
22d. PHYSICIAN'S NAME (Type) <b>Dr. Rex R. Martin M.D.</b>					22e. ADDRESS <b>220 N. Market Street Frederick, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-4-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Church of Brethren Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Brownsville, Washington, Md.</b>			
24. FUNERAL DIRECTOR <b>Robert E. Dailley &amp; Son</b>				ADDRESS <b>Frederick, Maryland</b>		25a. REC'D BY REGISTRAR <b>OCT 2 1968</b>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1. The first part of the report is a general  
introduction to the subject of the study.  
2. The second part is a description of the  
methodology used in the study.  
3. The third part is a description of the  
results of the study.  
4. The fourth part is a discussion of the  
results of the study.  
5. The fifth part is a conclusion of the  
study.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

M

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
14408					14415					
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH		2b. HOUR			
Ada F. Main					Oct. 5 1968		11:10			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Female		White		July 26, 1882		88 YRS		MONTHS DAYS		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U.S.A.				Frederick Md				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Frederick		Frederick Mem. Hospital		Housewife		Own Home				
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland		Frederick		Middletown				W. Main St.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
George H. Bidle			Mary E. Brown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17 INFORMANT					
NO			212-50-8194		Mrs. Mary Morgan Middletown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Sudden death &amp; cerebral &amp; cardiovascular</u> <u>arteriosclerosis &amp; possible little stroke</u> <u>1 year</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) _____										
DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
34 X										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION		21g. LOCATION (City or Town) County State			
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					Street or R.F.D. No					
22a. I certify that (I) (this hospital) attended the deceased from _____, 1934, to 10-15, 1968, that (I) (we) last saw the deceased alive on 10-15-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE		ATTENDING PHYS		22c. DATE SIGNED	
<u>Rex R. Martin</u>							<input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS		Oct. 17, 1968	
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
Rex R. Martin					Frederick Md					
23a. BURIAL, CREMATION, or other disposition (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		Oct. 18, 1968		Lutheran Cemetery		Middletown Fred. Md.				
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Gladhill Co. Middletown, Md.					DATE OCT 18 1968		<u>J. Charles Judge</u>			

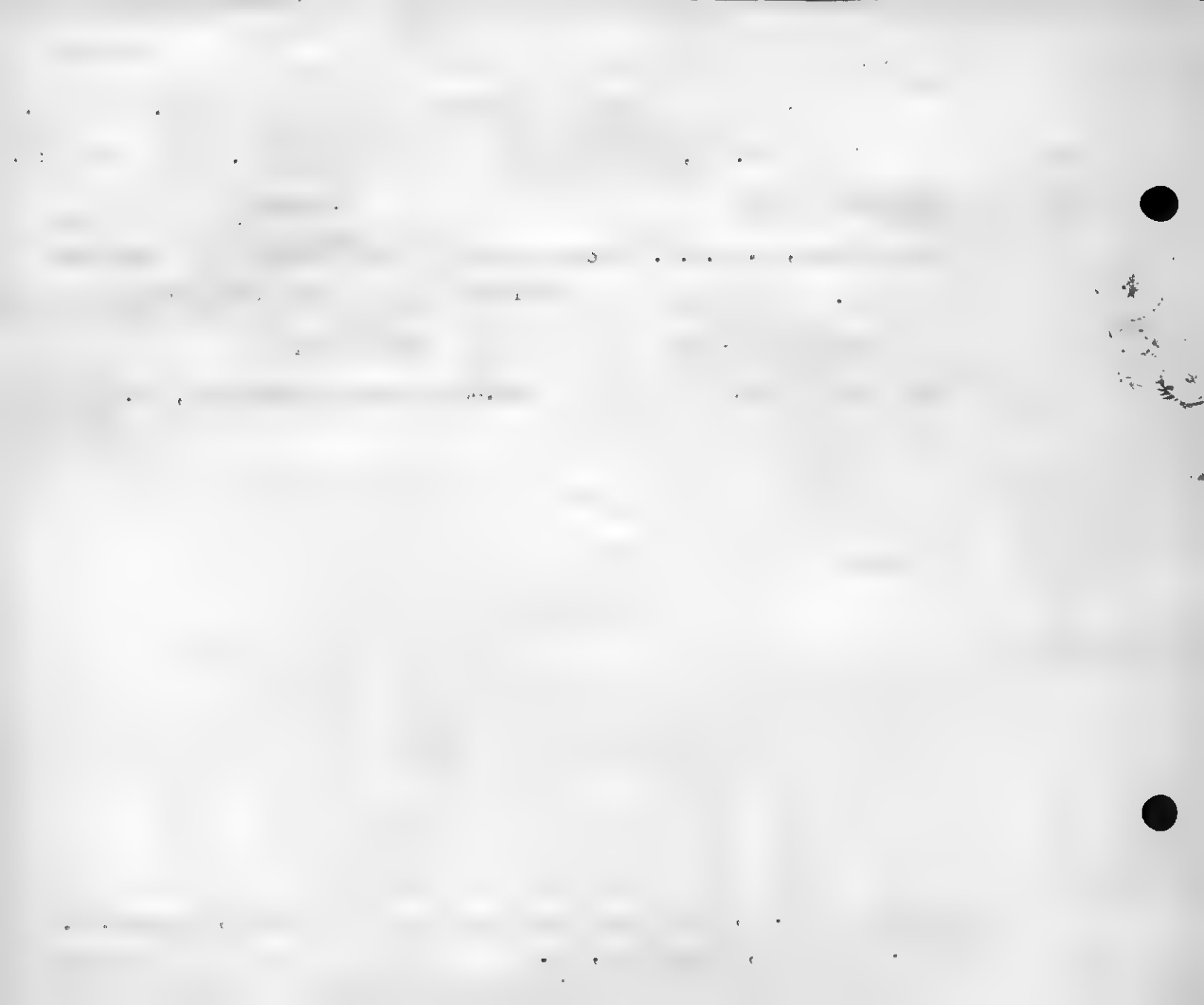




TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1 above. Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Virgil Guy Morgan						Month Day Year			2b. HOUR		
3 SEX			4. RACE			5. DATE OF BIRTH			6. AGE (in years last birthday)		
Male			White			Oct. 19, 1968			44 YRS		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. COUNTY OF DEATH		
Maryland			USA			NEVER MARRIED			Frederick		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. US A. OCCUPATION (Kind of work during most of working life even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Near Emmitsburg, Md.			D.O.A. Frederick Memorial			Single Man Dept.			Railroad		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Md.			Washington			Hagerstown			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER			14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES?		
1016 Fairview Road			First Middle Last			First Middle Last			Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
			Chester Morgan			Lina Lena Oster			War II Navy		
16a. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		
216-18-1259			Mrs. Ruth Morgan, Hagerstown, Md. Wife						PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation		
									817 9 DUE TO, OR AS A CONSEQUENCE OF		
									(b) Aspiration Apoplexy - Blood		
									DUE TO, OR AS A CONSEQUENCE OF		
									(c) Fracture Mandible		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION											
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?											
20. AUTOPSY?											
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			7-11 P.M. 10-19-68			Two Vehicle Collision					
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town		
			Highway			Emmitsburg - Frederick - Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MED. CAL EXAMINER			ASSISTANT MEDICAL EXAMINER			22b. DATE SIGNED		
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER						Oct. 20, 1968		
			ADDRESS (Street, city, town, or county)								
23a. BURIAL, CREMATION, OR REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			Oct. 23, 1968			Sunset Memorial Park			Cumberland, Allegany, Md.		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
James F. Scarpelli, Cumberland, Md.						DATE OCT 22 1968			Charles Judge		



CERTIFICATE OF DEATH

14417

14410

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

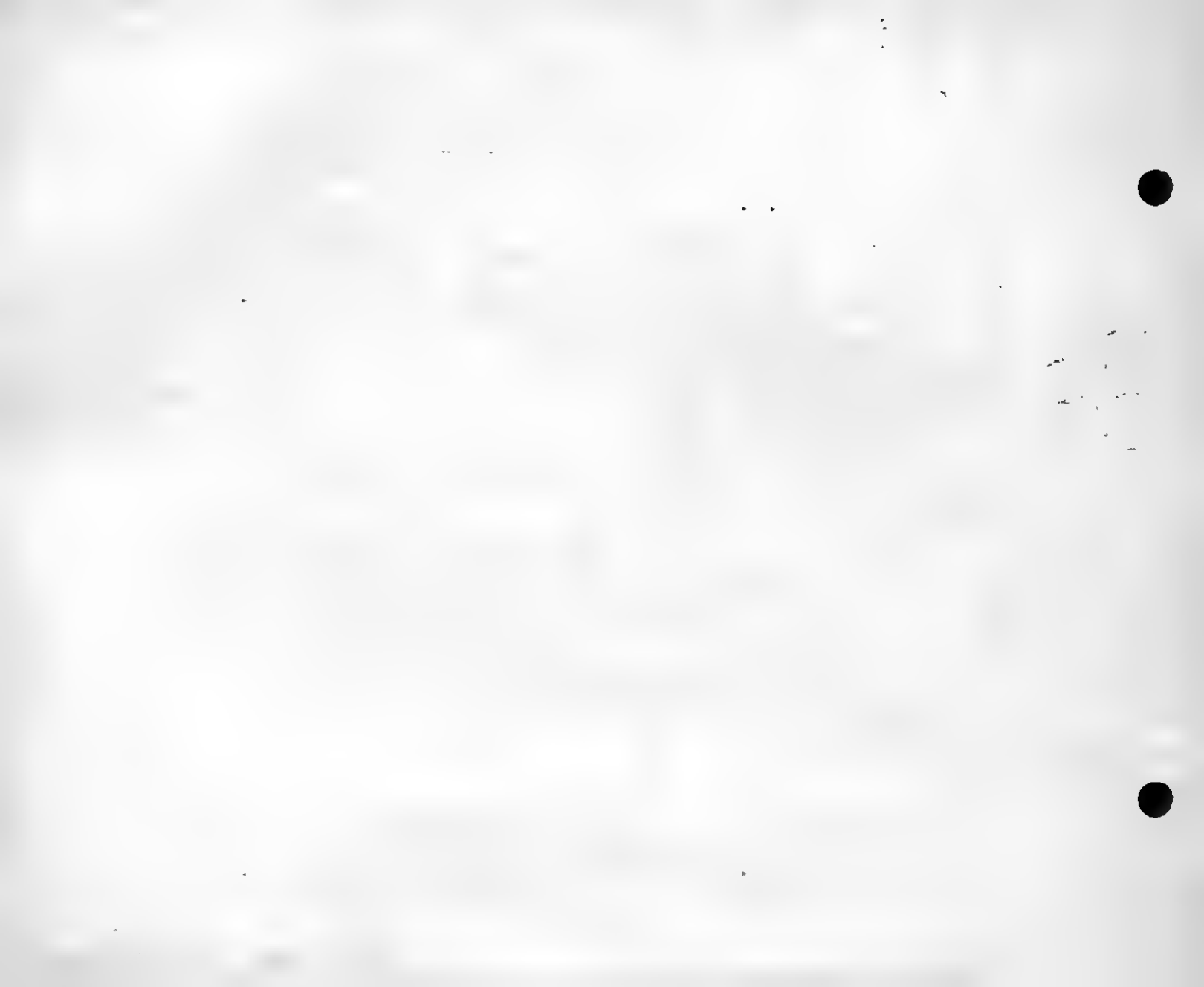
1 DECEASED-NAME (Type or print) First Middle Last Helen Elizabeth Newman			2a. DATE OF DEATH Month Day Year October 22 1968		2b. HOUR a.m. or p.m. 6:45 M
3 SEX Female	4. RACE White	5. DATE OF BIRTH July 7, 1873		6. AGE (In years last birthday) 95 YRS.	7. UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Frederick Md.		
10. CITY OR TOWN OF DEATH Braddock Heights	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Vindabona Conv. & Rest Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housework		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) - STATE Maryland	13b. COUNTY Frederick	13c. CITY OR TOWN Frederick	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 42 East Patrick Street	
14. FATHER'S NAME First Middle Last Jacob M. Newman	15. MOTHER'S MAIDEN NAME First Middle Last Catherine Shaw		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No		
16b. SOCIAL SECURITY NO.		17 INFORMANT Frederick, Md. Parsons Newman, 303 Upper College Terrace.			
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular Generalized -</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min 2 yrs
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 332x <u>Smoking</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC.	21f. LOCATION Street or R.F.D. No	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>June 19, 1968</u> , to <u>Oct 22, 1968</u> , that (I) (we) lost saw the deceased alive on <u>Oct 22, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>A. T. Brice</u>		DEGREE	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED Oct. 22, 1968	
22d. PHYSICIAN'S NAME (Type) A. T. Brice, M.D.		22e. ADDRESS Jefferson, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Oct. 24, 1968	23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Frederick Frederick Md.		
24 FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland	25a. REC'D BY REGISTRAR OCT 25 1968	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14411										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										14418														
1 DECEASED NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR														
Blanche Mae Norris										October 4 1968										11:30 AM														
3. SEX			4 RACE			5 DATE OF BIRTH			6 AGE (In years last birthday)			7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH			12b. KIND OF BUSINESS OR INDUSTRY										
Female			Negro			7-28-1388			80			Md			U.S.A.			Frederick			Md.			*****										
10. CITY OR TOWN OF DEATH					11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY																			
Frederick					Frederick Memorial Hospital					Housewife					*****																			
13a. USUAL RESIDENCE (Where deceased lived, if institution)					13b. CITY OR TOWN					13c. INSIDE CITY LIMITS?					13e. STREET AND NUMBER																			
Md					Frederick					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					21 W. All Saints St.																			
14 FATHER'S NAME					15. MOTHER'S MAIDEN NAME					16a. WAS DECEASED EVER IN U.S. ARMED FORCES?					16b. SOCIAL SECURITY NO					17 INFORMANT					Address									
Joseph NMN					Laura NMN					No					UNKN					Robert Squirell					Westminster									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					18b. SOCIAL SECURITY NO					17 INFORMANT					Address					Md														
PART I. DEATH WAS CAUSED BY.					18b. SOCIAL SECURITY NO					17 INFORMANT					Address					Md														
IMMEDIATE CAUSE (a)					18b. SOCIAL SECURITY NO					17 INFORMANT					Address					Md														
4120					UNKN					Robert Squirell					Westminster					Md														
DUE TO, OR AS A CONSEQUENCE OF					18b. SOCIAL SECURITY NO					17 INFORMANT					Address					Md														
(b) Arteriosclerotic Cardiovascular disease					UNKN					Robert Squirell					Westminster					Md														
DUE TO, OR AS A CONSEQUENCE OF					18b. SOCIAL SECURITY NO					17 INFORMANT					Address					Md														
(c)					UNKN					Robert Squirell					Westminster					Md														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					18b. SOCIAL SECURITY NO					17 INFORMANT					Address					Md														
nephrosclerosis & uremia					UNKN					Robert Squirell					Westminster					Md														
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
										YES <input type="checkbox"/> NO <input type="checkbox"/>																								
21a. ACCIDENT WAS UNDERLYING					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																								
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					HOUR A.M. Month Day Year																													
(If either, notify medical examiner)					P.M. 19																													
21d. INJURY OCCURRED					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)					21f. LOCATION					Street or R.F.D. No					City or Town					County					State				
Where <input type="checkbox"/> Not while <input type="checkbox"/>																																		
at work <input type="checkbox"/> at work <input type="checkbox"/>																																		
22a. I certify that (I) (this hospital) attended the deceased from					22b. SIGNATURE					22c. DATE SIGNED																								
5 SEP 1968, to 4 OCT 1968, that (I) (we) lost					George I. Smith, Jr					4 OCT 68																								
saw the deceased alive on 4 OCT 1968, and that in (my) (our) opinion death occurred on the date and hour and from the																																		
causes stated above, (I) (we) (did) (did not) view the body after death.																																		
22b. SIGNATURE					22c. DATE SIGNED																													
George I. Smith, Jr					4 OCT 68																													
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS																													
George I. Smith, Jr					304 Tell House, Frederick, Md																													
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town)					(County)					(State)									
Burial					10-9-68					Fairview					Frederick					Fred.					Md									
24 FUNERAL DIRECTOR					25a. REC'D BY REG STRAR					25b. REGISTRAR'S SIGNATURE																								
C.E. Hicks, 111 Frederick, Md					DATE					OCT 10 1968					Charles Judge																			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 2 and 3 and return them to the funeral director. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED-NAME (Type or print) Cecil Benjamin Pryor						2a DATE OF DEATH Oct. Month 8 Day 1968				2b. HOUR 2:25p		
3. SEX Male		4. RACE White		5. DATE OF BIRTH June 8, 1961		6 AGE (In years lost birthday) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Frederick Md.						
10. CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Mem. Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of work'ng life, even if retired) Salesman			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. CITY Frederick		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 116 Brooklawn		
14 FATHER'S NAME First Middle Last Ira E. Pryor				15 MOTHER'S MAIDEN NAME First Middle Last Orpha V. Hauver								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO				16b. SOCIAL SECURITY NO. 578-07-324		17. INFORMANT Mrs. Faith K. Pryor				Address 116 Brooklawn Frederick, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>4301</u> (b) <u>Chronic bronchitis and emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs.		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>and 1.5 hr.</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <u>July 13</u> , 19 <u>68</u> , to <u>Oct 8</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>10/8/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death												
22b. SIGNATURE <u>A. Austin Pearre Jr.</u>						DEGREE ATTENDING PHYS.		MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>10/8/68</u>		
22d. PHYSICIAN'S NAME (Type) A. Austin Pearre Jr.						22e. ADDRESS 804 TollHouse Ave. Fred. Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Oct. 11, 68		23c. NAME OF CEMETERY OR CREMATORY Reformed Church Cem.		23d. LOCATION (City or Town) (County) (State) Middletown Fred. Md.						
24. FUNERAL DIRECTOR Gladhill Co. Middletown, Md.				25a. REC'D BY REGISTRAR DATE OCT 11 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge						

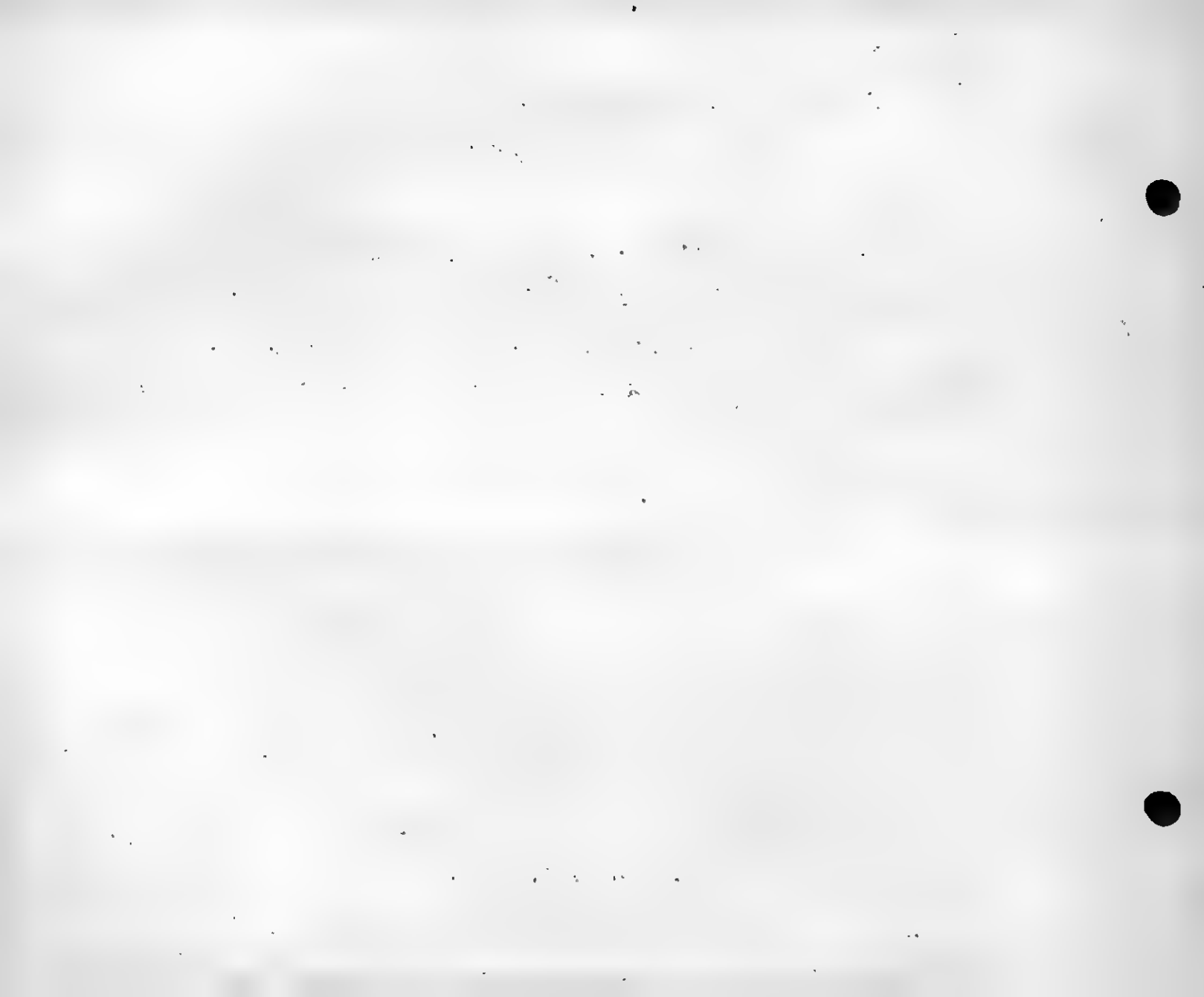




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
<div> <div>10-31-68 mt</div> <div>14413</div> <div>CERTIFICATE OF DEATH</div> <div>14420</div> </div>										
1 DECEASED-NAME (Type or print) First Middle Last					2a. DATE OF DEATH Month Day Year		2b. HOUR			
MARK HOWARD RAMSBURG					Month Oct Day 7 Year 68		6:10 A M			
3. SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		
M		W		DEC 7 - 1967		YRS. 36		DAYS		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARR ED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
MARYLAND		USA				FREDERICK Md				
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
FREDERICK			MEMORIAL HOSPITAL			NONE		NONE		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
MARYLAND			FREDERICK		LIBERTY RURAL		YES		NONE	
14 FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last					
ROBERT S RAMSBURG					NOLA BARNES					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give year or dates of service)			16b SOCIAL SECURITY NO		17 INFORMANT Address					
NO			NONE		ROBERT RAMSBURG UNION BRIDGE R2					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Septicemia										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
(b) Burn - 36%									3	
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
111										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, not notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		8:30 A.M. 10-3-68		Fell into tub of hot water						
21d INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State						
		Home		Rt. 2 Union Bridge, Md.						
22a. I certify that (this hospital) attended the deceased from Oct 3, 1968 to Oct 7, 1968, that (I) (we) last saw the deceased alive on Oct 7, 1968, and that in (my) (our) opinion, death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
Edward J. Koenigsberg MD									Oct 7, 1968	
22d. PHYSICIAN'S NAME (Type)					22e ADDRESS					
EDWARD J KOENIGSBURG					FREDERICK MD					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
BURIAL		OCT 9 - 1968		LINCANORE		UNIONVILLE MD				
24. FUNERAL DIRECTOR ADDRESS					25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
D D Hartzler + Sons New Windsor					DATE OCT 10 1968		J Charles Judge			

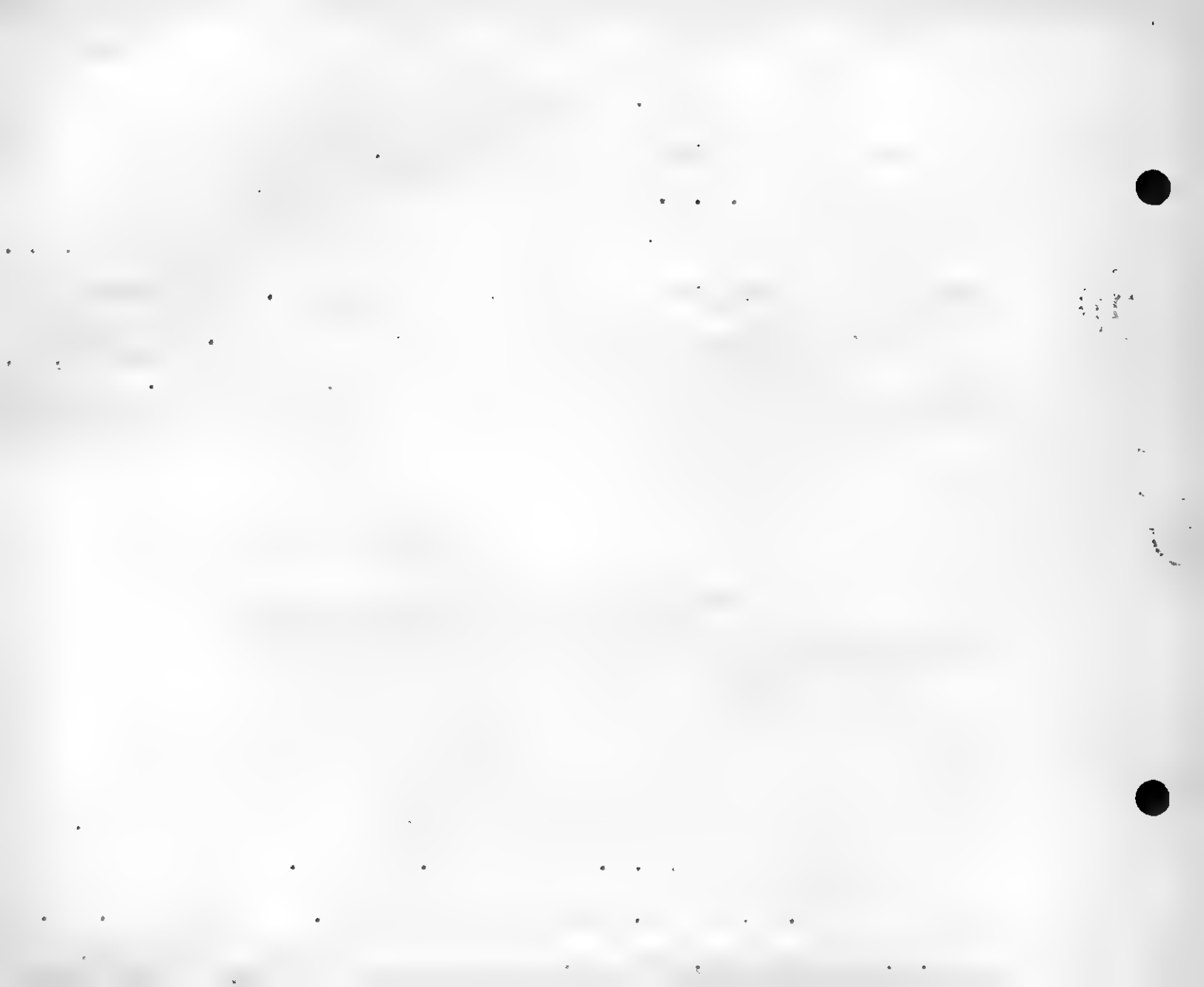


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
304 REV

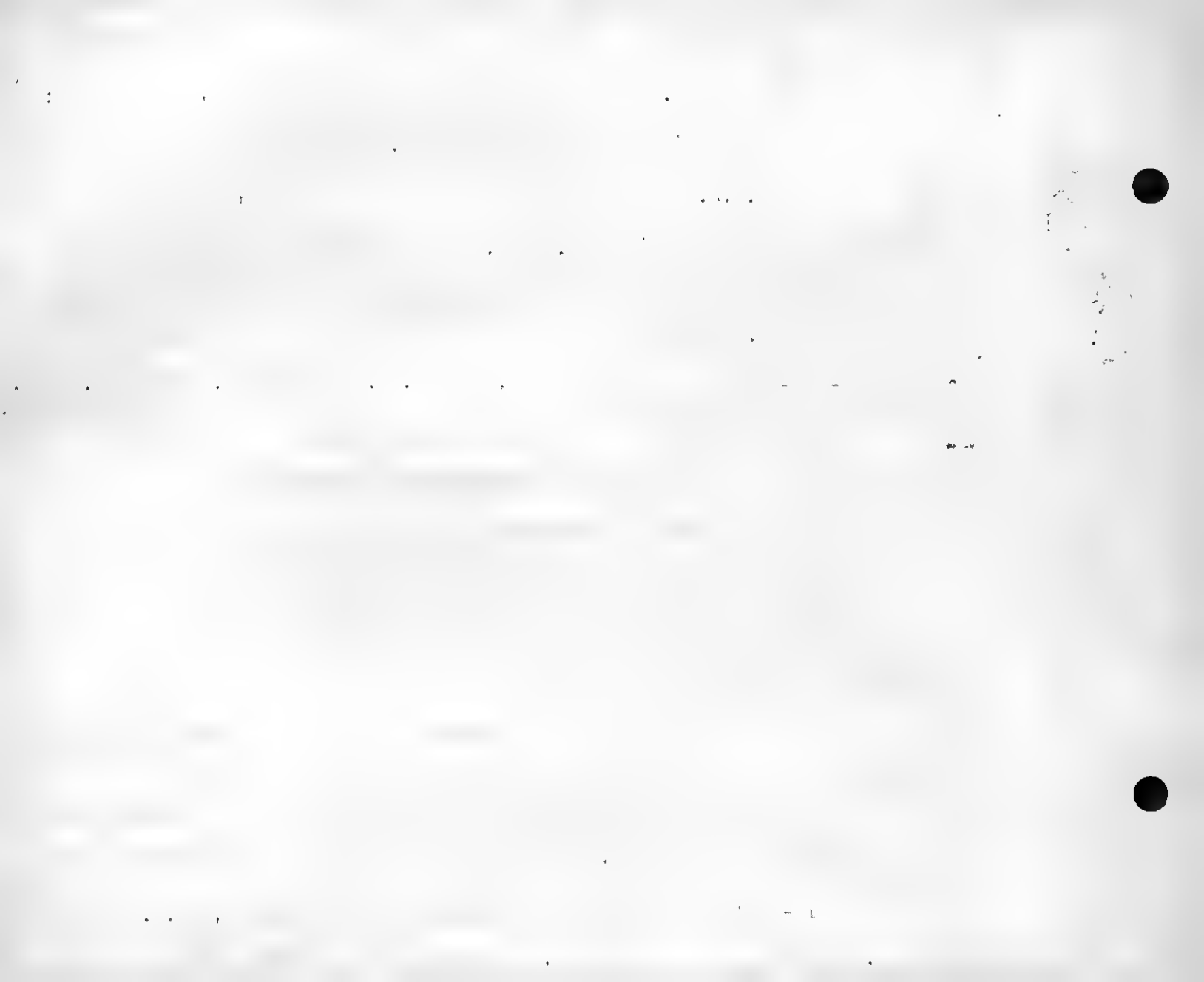
MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <b>ANNA</b>			First <b>M.</b>		Middle <b>ROGERS</b>		Last		2a. DATE OF DEATH Month <b>October</b> Day <b>14</b> Year <b>1968</b>	2b. HOUR <b>9 A M</b>
3. SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>October 25, 1903</b>			6 AGE (In years last birthday) <b>64</b> YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8- MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Frederick</b>			Md.	
10. CITY OR TOWN OF DEATH <b>Frederick</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Frederick Nursing Center</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Nursing, R.N.</b>	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b COUNTY <b>Frederick</b>		13c CITY OR TOWN <b>Frederick</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>321 N. Market Street</b>	
14. FATHER'S NAME First <b>Charles</b> Middle <b>Arunah</b> Last <b>Rogers</b>			15. MOTHER'S MAIDEN NAME First <b>Nora</b> Middle <b>G.</b> Last <b>Hardey</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)				
16b. SOCIAL SECURITY NO.			17. INFORMANT Address <b>Pittsburgh, Pa.</b> <b>Miss Louise Rogers, 245 Lothrop St.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of pancreas</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State		
22a I certify that (I) (this hospital) attended the deceased from <b>August, 1968</b> , to <b>10/14, 1968</b> , that (I) (we) lost saw the deceased alive on <b>10/17, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>James B. Thomas, M.D.</b>					22c. DATE SIGNED <b>October 15, 1968</b>		22d. PHYSICIAN'S NAME (Type) <b>James B. Thomas, M. D.</b>			
23a. BURIAL, CREMATION, REMOVAL, (Specify)		23b. DATE <b>Oct. 17, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>nr. Buckeystown Fred. Md.</b>				
24. FUNERAL DIRECTOR <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>					25a. REC'D BY REGISTRAR DATE <b>OCT 17 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be prepared within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14415		14422						1	
1 DECEASED-NAME (Type or print) <b>JEANE B. SMITH</b>			2a. DATE OF DEATH <b>October 29, 1968</b> Year			2b. HOUR a.m. or p.m. <b>9:45</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>March 13, 1906</b>		6. AGE (In years last birthday) <b>62</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Frederick, Md.</b>			
10. CITY OR TOWN OF DEATH <b>Fredesrick</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Frederick Mem. Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Frederick</b>		13c. CITY OR TOWN <b>Frederick</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>121 West Church Street</b>	
14. FATHER'S NAME First Middle Last <b>Mortimer K. Brigstocke</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Marie Dunbar</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>(If yes give war or dates of service)</b>		17. INFORMANT Address <b>Mr. John A. G. Smith 121 N. Church St. Fred.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> <b>5631</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Peritonitis &amp; Fluid-Electrolyte Imbalance</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Acute Enterocolitis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Md.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>211</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>October 27, 1968</b> to <b>October 29, 1968</b> , that (I) (we) last saw the deceased alive on <b>October 29, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>James B. Thomas</b>				22c. DATE SIGNED <b>October 29, 1968</b>		22d. PHYSICIAN'S NAME (Type) <b>James B. Thomas, M. D.</b>			
22e. ADDRESS <b>228 N. Market St., Frederick, Md.</b>									
23a. BURIAL, CREMATION, OR OTHER DISPOSAL <b>Cremation</b>		23b. DATE <b>10-31-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>			
24. FUNERAL DIRECTOR <b>Robert E. Dailey &amp; Son</b>				ADDRESS <b>Frederick, Maryland</b>		25a. REC'D BY REGISTRAR <b>NOV 1 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



14416

CERTIFICATE OF DEATH

14423

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) <b>JESSIE GRACE SMITH</b>			2a. DATE OF DEATH Month <b>OCT</b> Day <b>19</b> Year <b>1968</b>			2b. HOUR <b>1A</b> M								
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>MARCH 11-1889</b>		6. AGE (In years last birthday) <b>79</b> YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN _____				
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>FREDERICK</b> Md.								
10. CITY OR TOWN OF DEATH <b>UNION BRIDGE RURAL</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>COOPERMINE RD</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if ret. red.) <b>HOUSEWIFE</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>			13b. COUNTY <b>FREDERICK</b>			13c. CITY OR TOWN <b>UNION BRIDGE</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER <b>COOPERMINE RD.</b>		
14. FATHER'S NAME First Middle Last <b>HENRY KERSHAW</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>MARY WALKER</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown (If yes give war or dates of service) <b>NO</b>			16b. SOCIAL SECURITY NO <b>217-16-2889</b>			17. INFORMANT Address <b>ROUTE 7 FREDERICK, MD</b> <b>MRS LEWIS A. RICE</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4129 Arteriosclerotic CVD</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____								
22a. I certify that (I) (this hospital) attended the deceased from <b>10/17, 1968</b> , to <b>10/17, 1968</b> , that (I) (we) last saw the deceased alive on <b>10/19/68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <b>M.E. Robertson</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>10/19/68</b>					
22d. PHYSICIAN'S NAME (Type) <b>ME. ROBERTSON</b>						22e. ADDRESS <b>New Windsor Md</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>10-22-68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>FAIRMOUNT CEM.</b>			23d. LOCATION (City or Town) (County) (State) <b>LIBERTYTOWN MD</b>					
24. FUNERAL DIRECTOR <b>DD Hutzler &amp; Son</b>						25a. REC'D BY REGISTRAR <b>Libertytown Md</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					





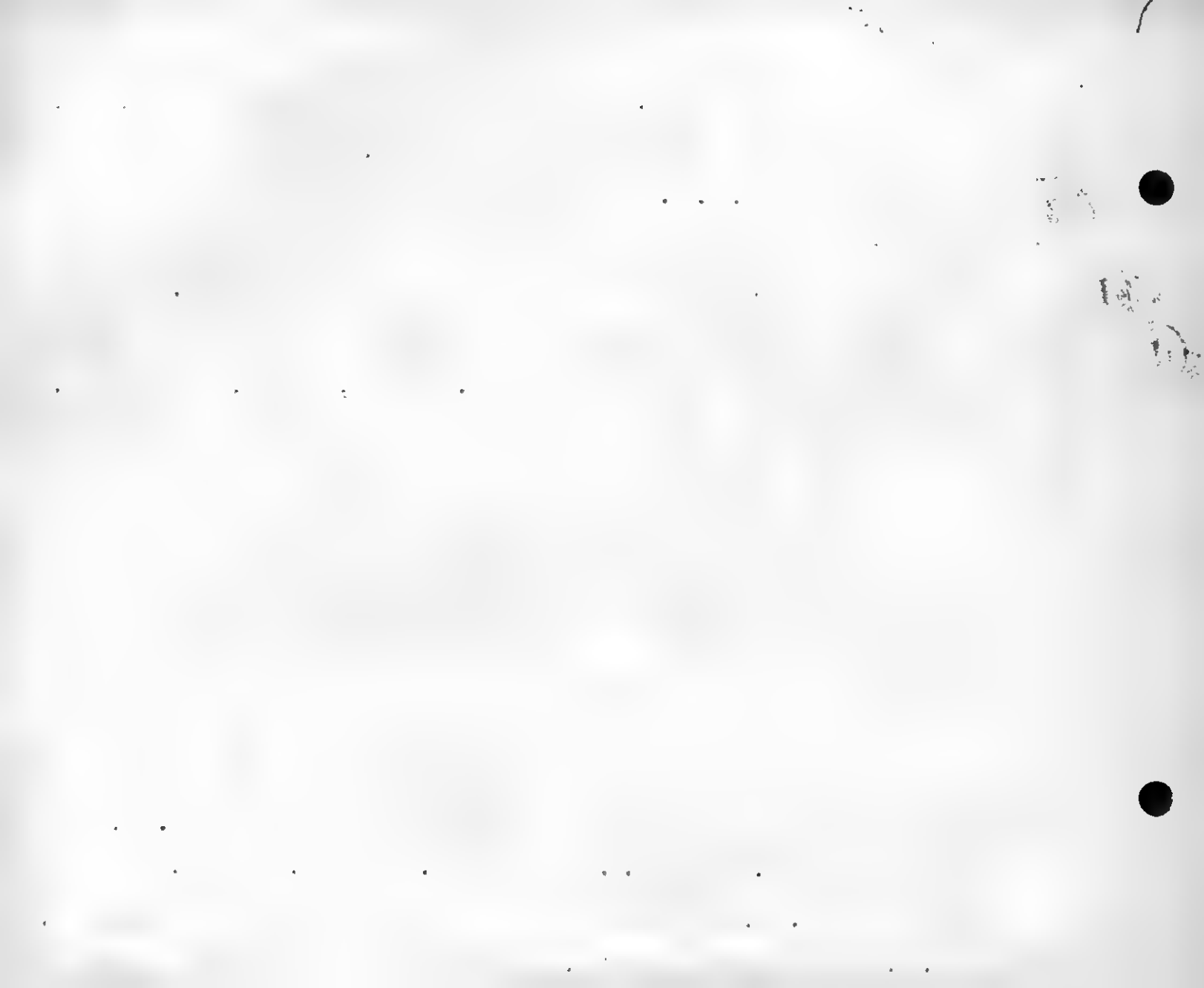
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VR A15  
30M REV

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month		Day	Year	2b. HOUR P M
NETTIE		B.	STOCKMAN		October		17	1968	3:35
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS
Female	White		September 16, 1885		83 YRS				
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland	U. S. A.				Frederick Md				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Frederick		Frederick Memorial Hospital		Housewife					
13a. USUAL RESIDENCE (Where deceased admitted) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Frederick		Frederick				61 Taney Apt.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
James			Greenwald		Mary Ann Measell				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT					
No		216 22 1668		John W. Stockman, Route 2, Middletown, Md.					
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Nephrosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days -</u> <u>? years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/14</u> , 19 <u>68</u> , to <u>10/17</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10/17</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>James B. Thomas</u>				DEGREE ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Oct. 18, 1968	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
James B. Thomas, M.D.				228 N. Market St. Frederick, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		Oct. 20, 1968		Lutheran Cemetery		Jefferson Frederick		Md.	
24. FUNERAL DIRECTOR				25a. REC'D BY REG. STR.		25b. REGISTRAR'S SIGNATURE			
M. R. Etchison & Son, Frederick, Maryland				OCT 21 1968		<u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and show them to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14425

1 DECEASED-NAME (Type or print) <b>Howard</b>		First <b>Howard</b>	Middle <b>M.</b>	Last <b>Stroup</b>	2a. DATE OF DEATH <b>Oct.</b> Month <b>27</b> Day <b>68</b> Year		2b. HOUR <b>10:30</b> M	
3 SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>October 31-1922</b>		6 AGE (In years Last birthday) <b>45</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Frederick</b> Md		
10. CITY OR TOWN OF DEATH <b>Frederick</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Frederick Mem. Hospital</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Sales representative</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Retail Store</b>		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Frederick</b>		13c CITY OR TOWN <b>Frederick</b>		13d INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>14 E. 5th. St.</b>
14. FATHER'S NAME <b>Harry</b>		First <b>Harry</b>	Middle <b>M.</b>	Last <b>Stroup</b>	15 MOTHER'S MAIDEN NAME <b>Ella</b>		First <b>Ella</b>	Middle <b>Mae</b>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>214-14-6951</b>		17 INFORMANT <b>Frederick</b>		Address <b>Md. 21701</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease - acute</u> DUE TO OR AS A CONSEQUENCE OF <u>myocardial infarct + cardiac stand still</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 1/2 hours</b>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4201</b>								
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED Where <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a I certify that (I) (this hospital) attended the deceased from <u>10-27, 1968</u> , to <u>10-27-1968</u> , that (I) (we) last saw the deceased alive on <u>10-27-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE <u>B. R. Martin</u>		DEGREE <b>PHYS.</b>		ATTENDING <input checked="" type="checkbox"/> MED <input type="checkbox"/> STAFF <input type="checkbox"/> PHYS. DIRECTOR PHYS.		22c DATE SIGNED <b>10-27-68</b>		
22d PHYSICIAN'S NAME (Type) <u>B. R. Martin</u>		22e ADDRESS <u>Frederick, Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE <b>Oct. 30-1968</b>		23c NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d LOCAT ON (City or Town) (County) (State) <b>Frederick, Md. 21701</b>		
24. FUNERAL DIRECTOR <u>Elwood T. M. R. Etchison &amp; Son</u>		ADDRESS <u>Frederick, Md. 21701</u>		25a. REC'D BY REGISTRAR <b>OCT 31 1968</b>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



14419

## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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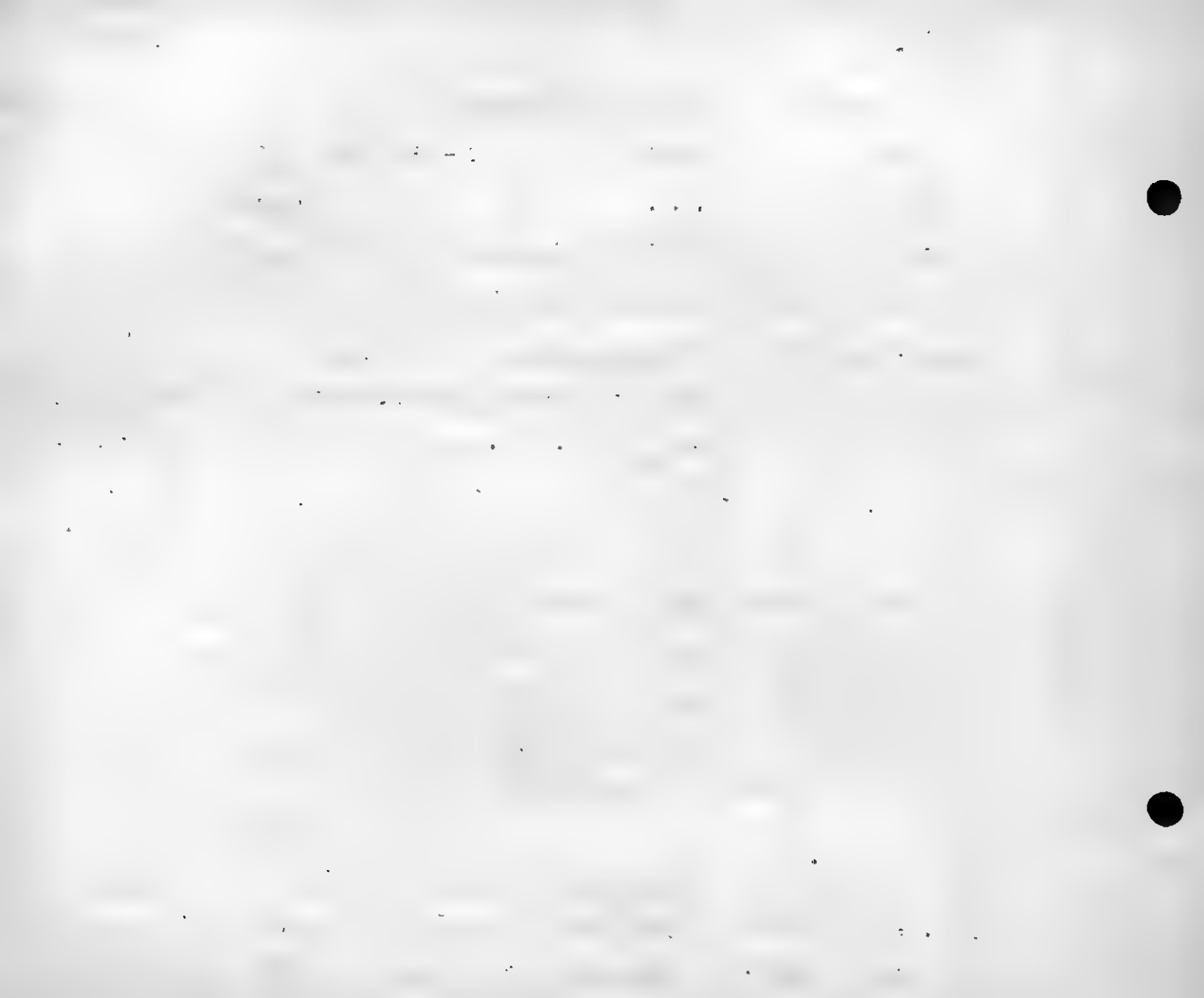
1. DECEASED-NAME (Type or print) <b>MELVIN</b>			First	Middle	Last	2a. DATE OF DEATH Month <b>October</b> Day <b>10</b> Year <b>1968</b>			2b. HOUR <b>4:30</b> M	
3 SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>August 14, 1890</b>		6. AGE (In years last birthday) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>
7a. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Frederick</b> Md.				
10. CITY OR TOWN OF DEATH <b>Braddock Heights</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Windabona Conv. &amp; Rest Home</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired B &amp; O Carman</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>Maryland</b>		13b. COUNTY <b>Frederick</b>		13c. CITY OR TOWN <b>Brunswick</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>814 East B St.</b>		
14. FATHER'S NAME <b>Reed T. Thompson Sr.</b>			First	Middle	Last	15. MOTHER'S MAIDEN NAME <b>Susan Ann Kidwiler</b>			First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>705-10-2851</b>		17. INFORMANT <b>Mrs. Daisy Thompson</b>		Address <b>814 East B St Brunswick, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>41</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized arteriosclerosis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>5 days</b> <b>5 yrs</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4501</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <b>19</b> Month <b>10</b> Day <b>10</b> Year <b>1968</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>10/2, 1968</b> to <b>10/10, 1968</b> , that (I) (we) last saw the deceased alive on <b>10/9, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>A. Talbott Brice, M.D.</b>					REGREE <b>Jefferson, Maryland</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>October 10, 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>A. Talbott Brice, M.D.</b>					22e. ADDRESS <b>Jefferson, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Oct. 12/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Lovettsville Loudoun Va.</b>			
24. FUNERAL DIRECTOR <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>					25a. REC'D BY REGISTRAR <b>OCT 14 1968</b>		25b. REGISTRAR'S SIGNATURE <b>James J. Jones</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
14420 CERTIFICATE OF DEATH 14427										
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR		
Charles Howard Tregoning						10 5 68		11:30		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		7. UNDER 1 YEAR MONTHS DAYS		
Male		Caucasian		2 - 15 - 1893		75 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U.S.A.				Frederick Md.				
1d. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Frederick		Frederick Nursing Center				Contractor		Building		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Frederick		Frederick		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Route # 1	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Samuel Tregoning			Clara Kidd							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give year or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No			212-14-6518A		Mr. Howard Tregoning		1709 W. 7th St. Fred			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bacterial &amp; esophageal hemorrhage</u>									5 days	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized carcinoma</u>									1 year	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Bronchogenic carcinoma</u>									18 mos.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
16d.										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from June, 1957, to Oct. 5, 1968, that (I) (we) last saw the deceased alive on Oct. 1, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE E. A. Dettbarn, M.D. DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10/7/68			
22d. PHYSICIAN'S NAME (Type) E. A. DETTBARN					22a. ADDRESS Walleroville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		10/8/68		Mt Hope cemetery		Woodsboro, Frederick, Md.				
24. FUNERAL DIRECTOR G. E. Barton, Walkersville, Md. 21793					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
					DATE OCT 9 1968		Charles Judge			





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
<div>14421</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>14428</div>											
1 DECEASED-NAME (Type or Print)			First		Middle		Last		2a. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year <input type="checkbox"/> 10/13/68 19		
Fred			Ufheil						2b HOUR 10A M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 F UNDER YEAR MONTHS	8 YRS.	9 IF UNDER 24 HRS			2c. DATE PRONOUNCED DEAD Month Day Year Oct 13, 1968 19		
male	white	April 12, 1890	78						2d HOUR M		
7a BIRTHPLACE (State or foreign country)		7b CIT ZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Frederick Md.					
New York		U S A									
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Frederick			Memorial Hospital			Retired			Cement Finisher		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Md			Pro Georges			Suitland				4716 Huron St.	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
Carl Ufheil				Eva Eherhardt							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS				
yes			213 12 1026		George Ufheil		Colmar Manor, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
F. Gasch			Roberts							22b DATE SIGNED Oct 13, 1968	
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County) (State)		
Burial			10/17/68		Arlington National		Arlington		Va		
24. FUNERAL DIRECTOR						25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
F. Gasch's Sons Hyattsville, Md.						DATE OCT 16 1968		J. Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please deliver carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14422		CERTIFICATE OF DEATH						14429	
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
DENISE			DAWN VAN WINKLE			Oct Month 25 Day 68 Year			12:45 PM
3 SEX	4 RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
F	W		24 Oct 68			— YRS.		19	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MD		USA				FREDERICK Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
FREDERICK			FREDERICK MEM.						
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MD			FREDERICK					118 W. 11th St	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
William Van Winkle			Mary Estlin Swick						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17 INFORMANT Address			
						Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 776.9 DUE TO, OR AS A CONSEQUENCE OF (b) Fetal atelectasis DUE TO, OR AS A CONSEQUENCE OF (c) Prematurity & immaturity									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 19 hours
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
7									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 24 Oct, 1968, to 25 Oct, 1968, that (I) (we) lost saw the deceased alive on 25 Oct, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
R. L. Guest MD		25 Oct 68							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
R. L. GUEST		6 W 3rd St, Frederick Md							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
REL TO HOSP.		10/25/68		FREDERICK MEMORIAL HOSP.		FREDERICK, FRED. MD.			
24. FUNERAL DIRECTOR		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
		DATE		OCT 31 1968		Charles Judge			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14422

14430

FOR STATE  
HEALTH DEPT.


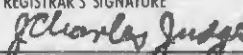
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 10 4 1968 11 M				2b. HOUR	
Walter Greenberry Warfield, Jr											
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year		2d. HOUR	
Male	Negro	12-27-1939	29 YRS					10 4 1968		11 PM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md.	
Maryland		U.S.A.				Frederick					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
New London Market			Rt 75			Construction			***		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY - IN TSP? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md				Frederick		New London		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt 1 Mt Airy, Md	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Walter Greenberry Warfield						Elizabeth NMN					Johnson
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS					
Yes <input type="checkbox"/> Unkn <input checked="" type="checkbox"/>			220-34-7370			Elizabeth J. Warfield Rt 1 Mt. Airy					
18. CAUSE OF DEATH (Enter only one cause per age for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Hemorrhage - Peritoneal Cavity</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Lacerated Liver</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>823.1</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <u>Oct 4 1968</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) <u>Car ran off road</u>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Highway</u>		21f. LOCATION Street or R.F.D. No. City or Town County State <u>Rte 75 - New Market - Frederick - Md.</u>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <u>Robert J. Thomas</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS STANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)				22b. DATE SIGNED <u>Oct 5, 1968</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial		10-8-68		Dersey Chapel			New London Fred. Md				
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
C.E. Hicks, 111 Frederick, Md				DATE <u>OCT 10 1968</u>		<u>J. Charles Judge</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) <b>RUSSELL</b> <b>MILLARD</b> <b>WEBBER</b>						2a. DATE OF DEATH <b>Oct.</b> Month <b>21</b> Day <b>68</b> Year			2b. HOUR <b>7 P.M.</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>3/15/1904</b>		6. AGE (In years last birthday) <b>64</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Frederick</b> Md.					
10. CITY OR TOWN OF DEATH <b>Brunswick</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>715 E. Potomac St.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Ret. Track Foreman</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Frederick</b>		13c. CITY OR TOWN <b>Brunswick</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>715 E. Potomac St.</b>		
14. FATHER'S NAME First Middle Last <b>William Rossel</b> <b>Webber</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Carrie</b> <b>Gosnell</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>7650-777-48</b>		17. INFORMANT Address <b>Judith Conner Knoxville, Md.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Congestive Heart Failure 6 yrs. DUE TO, OR AS A CONSEQUENCE OF Coronary Insufficiency 6 yrs.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4201</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (the hospital) attended the deceased from <b>10-20, 1968</b> , to <b>10-21, 1968</b> , that (I) (we) last saw the deceased alive on <b>10-21, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.											
22b. SIGNATURE  DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <b>Oct. 23, 1968</b>					
22d. PHYSICIAN'S NAME (Type) <b>C. T. Byron Kao, M.D.</b>						22e. ADDRESS <b>Brunswick, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/24/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Reformed Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Knoxville-Frederick-Md.</b>					
24. FUNERAL DIRECTOR <b>Teste Funeral Home</b>				ADDRESS <b>Brunswick, Maryland</b>		25a. REC'D BY REGISTRAR <b>OCT 25 1968</b>		25b. REGISTRAR'S SIGNATURE 			

MEDICAL CERTIFICATION

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$$\int_{-\infty}^{\infty} f(x) \delta(x-a) dx = f(a)$$

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper for pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div style="display: flex; justify-content: space-between;"> <span>14425</span> <span>CERTIFICATE OF DEATH</span> <span>14432</span> </div>									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Clarence			B. Young			Oct. 11 1968		7:45M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		Mar. 12, 1892		78 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Maryland		U.S.A.				Frederick			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street-address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Braddock Heights			Vindabova Conv. Home			Farmer		Farm	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Frederick						
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Jonas Young			Anna S. Sigler						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
			227-22-2334			Mrs. Henry Lakin Jr. Jefferson, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i>									
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Myocardial Degeneration</i>									
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic Bronchitis Emphysema</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<i>5030 (Chronic) Generalized Arteriosclerosis</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>1910</i> , 19 <i>60</i> , to <i>1968</i> , that (I) (we) last saw the deceased alive on <i>1910</i> 19 <i>60</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>A. Talbott Brice</i>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) A. Talbott Brice M.D.						22e. ADDRESS Jefferson, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Oct. 14, 1968		Lutheran Cemetery		Middletown Fred. Md.			
24. FUNERAL DIRECTOR Gladhill Co.				ADDRESS Middletown, Maryland		25a. REC'D BY REGISTRAR DATE OCT 15 1968		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

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